

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3301

CERTIFICATE OF DEATH

03228

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) Lola E. Ahalt		First	Middle
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
10c. BIRTHPLACE (State or foreign country) Maryland		11. AGE (In years lost birthday) 85 yrs.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Henry Beachley	14. MOTHER'S MAIDEN NAME Rebecca Remsburg
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	INFORMANT Lloyd Ahalt, Middletown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH unknown	
199-2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/19 , 19 60 , to 3/28 , 19 60 , that I last saw the deceased alive on 3/26 , 19 60 , and that death occurred at 11:20 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Middleton, Md. DATE SIGNED 3/29/60	
ACTUAL SIGNATURE Kenneth C. Henson		PHYSICIAN'S NAME (Type) Dr. Kenneth Henson	
22o. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/31/1960	22c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery
22d. LOCATION (City, town, or county) Middleton		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE APR 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03229

3261

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Months 11	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 419 West South Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) SYLVIA		First IRENE	Middle ALEXANDER
4. DATE OF DEATH March 15, 1960	Month March	Dgy 15	Year 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 26, 1881
9. AGE (In years last birthday) 78	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Michael Anders		14. MOTHER'S MAIDEN NAME Mary Catherine Rhoderick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 213-24-9580	INFORMANT Mr. Horace M. Alexander-Same as Item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		INTERVAL BETWEEN ONSET AND DEATH 18 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Arterio-sclerotic heart dis. myocardial infarction	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) Frederick (State) Maryland
21. I certify that I attended the deceased from May 17, 1953 to 15 March, 1960 that I last saw the deceased alive on 17 Feb, 1960 , and that death occurred at 6:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles H. Conley Jr.</i>	ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 3/16/60		
PHYSICIAN'S NAME (Type) Charles H. Conley Jr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 18, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hope Cemetery	22d. LOCATION (City, town, or county) Woodsboro, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 21 '60
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haas</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3298

Reg. Dist. No.

03230

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Emmitsburg</i>		c. LENGTH OF STAY IN 1b <i>10 years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>at Saint Mary College</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Emmitsburg</i>	
3. NAME OF DECEASED (Type or print) <i>George Car Appleton</i>		4. DATE OF DEATH <i>March 23 1960</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>8/12/1900</i>		9. AGE (in years last birthday) <i>58 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Kitchen helper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>College</i>	11. BIRTHPLACE (State or foreign country) <i>Mass.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Unknown</i>	
14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>201-12-4460</i>		17. INFORMANT <i>Mt. St. Mary's records</i>	Address <i>Emmitsburg, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>491X</i> DUE TO <i>Bronchial pneumonia</i> INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Acute Alcoholism</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Emmitsburg</i> (County) <i>Frederick</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED <i>March 23, 1960</i>	
EXAMINER'S NAME (Type) <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-26-60</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Anthony Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Emmitsburg, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond E. Creager</i>		ADDRESS <i>Thurmont, Md.</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

81 39004748—HIGHLIGHTS OF THE UNITED STATES CENSUS OF 1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03231

3262

CERTIFICATE OF DEATH

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4		TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.				
I		1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND				
2		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 2 Hours				
3		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
4		3. NAME OF DECEASED (Type or print)	First RICHARD	Middle PORTER	Last BAER	4. DATE OF DEATH Month March	Day 10,	Year 19 60
5		5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH September 9, 1884	9. AGE (In years at birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
6		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman (Ret)		10b. KIND OF BUSINESS OR INDUSTRY Mfg. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
7		13. FATHER'S NAME John R. Baer		14. MOTHER'S MAIDEN NAME Margaret Schwearing				
8		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-10-2149		INFORMANT 122 Kline St Blvd., Mr. J. Emory Baer, Frederick, Maryland		
9		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO		<i>Myocardial Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs		
10		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pyrexia				5 years. 5 years.		
11		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18. While at work		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
12		20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
13		21. I certify that I attended the deceased from alive on 3/10 , 19 60		21. I certify that I attended the deceased from alive on 3/10 , 19 55 , to 3/10 , 19 60 , that I last saw the deceased and that death occurred at 2:25A M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Professional Building		DATE SIGNED 3/11/60
14		ACTUAL SIGNATURE <i>S. R. Schoolman</i>		M.D.				
15		PHYSICIAN'S NAME (Type) L. R. Schoolman, M.D.		Frederick, Maryland				
16		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 14, 1960		22c. NAME OF CEMETERY OR CREMATORIUM St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland
17		23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 14 '60		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Evans</i>

17801
CERTIFICATE OF DEATH

Indicate cause of death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3302

CERTIFICATE OF DEATH

Reg. Dist. No.

03232

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#4		c. LENGTH OF STAY IN 1b 3 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Teen Barnes Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick -Rural- R.D.#4	
3. NAME OF DECEASED (Type or print) MARSHALL		First COLUMBUS	Middle BAKER
4. DATE OF DEATH Month March		Month Day	Year 14, 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail Bread Route	10b. KIND OF BUSINESS OR INDUSTRY Salesman	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles W. Baker		14. MOTHER'S MAIDEN NAME Mollie Umberger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-18-1733	INFORMANT Mrs. Virginia I. Baker-Same as item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. Generalized Carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Melvin E. Lea</i>	ADDRESS (Street, city or town, state) Frederick Medical Center DATE SIGNED 3/17/60		
PHYSICIAN'S NAME (Type) Melvin E. Lea., M.D.	Frederick, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 18, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 21 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

HEAD TO STA 22150 - 5000

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3263

CERTIFICATE OF DEATH

Reg. Dist. No.

03233

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Three Pines Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First F	Middle Barnard
4. DATE OF DEATH 3		Month 3	Day 3
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH 1871		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Spanish American	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lawrence Himes, Knoxville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-1, 1960, to 6-15-60, 1960, that I last saw the deceased alive on 3-1, 1960, and that death occurred at 6-15-60 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state), DATE SIGNED ACTUAL SIGNATURE 115, Bourne Jr M.D. 6-15-60 PHYSICIAN'S NAME (Type) 416 Bourne Jr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-7-1960	22c. NAME OF CEMETERY OR CREMATORIAL Brethren
22d. LOCATION (City, town, or county) Brownsville, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE G. H. Holt		ADDRESS Brunswick, Maryland	24a. REC'D BY REGISTRAR DATE MAR 14 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

03234

3264

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICK CITY		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ADAMSTOWN, MARYLAND		d. STREET ADDRESS BOX 34		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK CITY HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First GORDON	Middle Dewitt	Last BEAM	4. DATE OF DEATH	Month March	Day 25	Year 1960
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 24, 1886	9. AGE (In years less birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dairy Farmer		10b. KIND OF BUSINESS OR INDUSTRY Dairy		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S/A		
13. FATHER'S NAME EDWARD BEAM				14. MOTHER'S MAIDEN NAME MARY KATE BENNETT				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI 577-18-5431		17. INFORMANT Mrs. Eunice Beam Adamstown, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Sub-acute myocardial infarction 17 days Generalized arteriosclerosis 330X Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus mild, Pulmonary Emphysema Part III. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> Part IV. TIME OF INJURY Month, Day, Year Hour a. m. Day Year p. m. 19 1960 Part V. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> Part VI. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Part VII. (City or town) (County) (State) Part VIII. DATE OF DEATH March 9, 1960 to March 25, 1960 Part IX. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Part X. ADDRESS 7 E. CHURCH ST. FREDERICK, Md. Part XI. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 3-29-60 NAME OF CEMETERY OR CREMATORIUM Arlington Natl. Cem. LOCATION (City, town, or county) (State) Arlington, Virginia Part XII. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland REC'D BY REGISTRAR Arthur S. Thomas REGISTRAR'S SIGNATURE Part XIII. DATE MAR 30 '60								

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3265

CERTIFICATE OF DEATH

Reg. Dist. No.

03235

1. PLACE OF DEATH a. COUNTY <i>Frederick</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>11 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JOHN EDWARD BEARD</i>		First <i>JOHN</i>	Middle <i>EDWARD</i>
4. DATE OF DEATH <i>March 11 1960</i>	Month <i>March</i>	Day <i>11</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 26 1878</i>
9. AGE (In years last birthday) <i>81</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
14. FATHER'S NAME <i>John D. Beard</i>	14. MOTHER'S MÄDEN NAME <i>Barbara Ellen Burrier</i>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>42-38-8607</i>	17. INFORMANT <i>Mrs. May E. Beard, Frederick, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>177X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>metastases to pelvis, spine, lungs</i> 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 1959</i> , to <i>March 11, 1960</i> , that I last saw the deceased alive on <i>10 March 1960</i> , and that death occurred at <i>8:20 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. Stoner Jr.</i>	M.D.	ADDRESS (Street, city or town, state) <i>Walkersville, Md.</i>	DATE SIGNED <i>12 March 60</i>
PHYSICIAN'S NAME (Type) <i>James E. Stoner Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/10/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Chapel Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Dr. Libertytown, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G.C. Barton</i>	ADDRESS <i>Walkersville, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>MAR 16 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3266 CERTIFICATE OF DEATH

Reg. Dist. No. 03236

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 345 East Patrick Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Effie		First May	Middle Bell
4. DATE OF DEATH March 8, 1960		Month March	Day 8
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 15, 1880		9. AGE (In years last birthday) 79	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 11
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS. Days 0	13. IF UNDER 24 HRS. Hours 0
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME William T. Umberger	
16. SOCIAL SECURITY NO. 212-24-6979		17. INFORMANT Mrs. Martha B. Mock	18. ADDRESS 345 East Patrick Street.
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)		20. INTERVAL BETWEEN ONSET AND DEATH 11/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> at work	22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 22f. (City or town) (County) (State)
22g. BURIAL, CREMATION, REMOVAL (Specify) Burial		22h. DATE THEREOF 3-11-1960	22i. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery
22j. LOCATION (City, town, or county) Frederick, Maryland		22k. RECORD BY REGISTRAR DATE MAR 11 1960	
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. Turner, Jr.		24b. REGISTRAR'S SIGNATURE Wm. S. Kraus	24c. ADDRESS 7 East Church Street Frederick, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 14 Form G258 3-10-60 et 03237

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Frederick Memorial Hospital			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VELMA	Middle LA RUE	Last BELL		
4. DATE OF DEATH	Month MARCH	Day 1	Year 1960		
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19-60		
9. AGE (In years last birthday) yrs. 1 14	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****	10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Frederick, Maryland		
12. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME Margaret Gray (Married Name Bell)				
15. FATHER'S NAME Herman Carter	16. SOCIAL SECURITY NO. -----				
17. INFORMANT Hospital Records	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 571.0 DUE TO Centro-enteritis - non-specific INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
19					
21. I certify that (I) (this hospital) attended the deceased from 3/1 1960 to 3/1 1960 , that (I) (we) last saw the deceased alive on 3/1 1960 , and that death occurred at 11:25 AM , from the causes and on the date stated above.					
22a. SIGNATURE <i>James B. Thomas</i>	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) James B. Thomas	22d. ADDRESS Professional Building - Fred. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 2-60	23c. NAME OF CEMETERY OR CREMATORIAL Long Hill	23d. LOCATION (City, town, or county) Hystown	(State) Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE C.E.Hicks III	ADDRESS Frederick, Maryland	25a. REC'D BY REGISTRAR Arthur S. Tins	25b. REGISTRAR'S SIGNATURE		
		DATE MAR 7 '60			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03238

3268			
1. PLACE OF DEATH a. COUNTY <i>Frederick</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>maryland</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Frederick</i>		c. LENGTH OF STAY IN 1b <i>3 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Frederick Memorial Hosp.</i>		e. STREET ADDRESS <i>Keymar</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Lulu Viola Birely</i>		First	Middle
		Lost	4. DATE OF DEATH
		Month	Day
		March	7
		Year	1960
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 28, 1878</i>	
9. AGE (In years last birthday) <i>81</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>	
		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
		11. BIRTHPLACE (State or foreign country) <i>maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Oliver David Birely</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Angell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i> (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>219-20-0308A</i>	
		17. INFORMANT <i>Mr. Lewis S. Birely, Jackson, Mich.</i>	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		<i>4 days</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO		<i>Cerebral hemorrhage</i>	
DUE TO		<i>Hypertension</i>	
(c)		<i>Arteriosclerosis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Obesity</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>March 4, 1960</i> to <i>March 7, 1960 that (I) (we) last saw the deceased alive on <i>March 7, 1960</i>, and that death occurred at <i>12 p.m.</i> from the causes and on the date stated above. </i>			
22a. SIGNATURE <i>G. A. Pearre</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
		22b. DATE SIGNED <i>3/7/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>A. A. PEARRE</i>		22d. ADDRESS <i>48. Church St., Frederick, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Mar. 10, 1960</i>	
		23c. NAME OF CEMETERY OR CREMATORIUM <i>Baugh Cemetery</i>	
		23d. LOCATION (City, town, or county) <i>Frederick, Md.</i> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>G. C. Barton</i>		ADDRESS <i>Walkersville, Md.</i>	
		25a. REC'D BY REGISTRAR <i>Arthur S. Krause</i>	
		DATE <i>MAR 10 '60</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03239

3303

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE PENNA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Rural Ijamsville		c. LENGTH OF STAY IN 1b 6 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. DAVIDS 75X-3	
3. NAME OF DECEASED (Type or print) Edith L Bonyun		d. STREET ADDRESS 601 GLEN MARYL A N G	
4. DATE OF DEATH March 3 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 7 1881
9. AGE (In years less than birthday) 78 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PA	12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME STEPHEN DOUGLASS LIPPINCOTT		14. MOTHER'S MAIDEN NAME HARRIET ORVILLA MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT RIGGS HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis 20 yrs (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 17, 1954</u> , to <u>March 3, 1960</u> , that I last saw the deceased alive on <u>March 3, 1960</u> , and that death occurred at <u>11:00M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Joseph Lerner PHYSICIAN'S NAME (Type) Joseph Lerner M.D.		M.D. <u>Ijamsdale Md.</u> DATE SIGNED <u>March 3 '60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF MAR 4-60	
22c. NAME OF CEMETERY OR CREMATORIUM FORT LINCOLN CEM		22d. LOCATION (City, town, or county) WASHINGTON D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lucian K. Falcone		ADDRESS New Market Md	
24a. REC'D BY REGISTRAR DATE MAR 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO RURAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Death

Name of Deceased

Name of Physician

Name of Hospital

Address of Deceased

Address of Hospital

Name of Deceased

Name of Hospital

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03240

CERTIFICATE OF DEATH

Reg. Dist. No.

3269

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b Since 3-23-60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First BERTHA	Middle LOUISE	Last BOWLUS
4. DATE OF DEATH	Month March	Day 30	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 June 1871
9. AGE (In years on birthday) 88	10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Fairplay, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Joseph M. Rowland		14. MOTHER'S MAIDEN NAME Ann Elizabeth Emmert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Rev. John S. Bowlus (Same as item #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus INTERVAL BETWEEN ONSET AND DEATH minutes			
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease 4 years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/23 , 19 60 to 3/29 , 19 60 , that I last saw the deceased alive on 3/29 , 19 60 , and that death occurred at 7:15A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard C. Reynolds, M.D.</i>		ADDRESS (Street, city or town, state) 9 E. Church St. DATE SIGNED 30 March 1960	
PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-2-60	22c. NAME OF CEMETERY OR CREMATORIUM Pleasant View Cemetery	22d. LOCATION (City, town, or county) (State) Near Burkittsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 1 1960	24b. REGISTRAR'S SIGNATURE C. L. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3304 CERTIFICATE OF DEATH

Reg. Dist. No.

03241

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		c. LENGTH OF STAY IN 1b 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary E. H. Bowlus		First Mary	Middle E.
4. DATE OF DEATH 3 28 1960	Month 3	Day 28	Year 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/28/1876
9. AGE (In years last birthday) 84 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.	13. FATHER'S NAME Lawson Haupt		
14. MOTHER'S MAIDEN NAME Mary Dutrow	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	INFORMANT J. Grayson Bowlus, Middletown, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO adv. arterio sclerosis			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 1959 to Mar 28 1960 , that I last saw the deceased alive on Mar 27 1960 , and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Elmer Harp		ADDRESS (Street, city or town, state) Middletown 3-29-60	
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3/30/1960	22c. NAME OF CEMETERY OR CREMATORIAL Lutheran Cemetery	22d. LOCATION (City, town, or county) (State) Middletown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. RECEIVED BY REGISTRAR MAR 31 1960	24b. REGISTRAR'S SIGNATURE Arthur L. Harp

11-5000
CERTIFICATE OF DEATH

1933

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3305 CERTIFICATE OF DEATH

Reg. Dist. No.

03242

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Md b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rte 7		c. LENGTH OF STAY IN 1b 191 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick County Chronic Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS	
First Flora		Middle Browning	
4. DATE OF DEATH		Month 3	
5. SEX		Day 29	
Female		Year 1960	
6. COLOR OR RACE		b. DATE OF BIRTH	
W. WIDOWED <input checked="" type="checkbox"/>		6/12/82	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost/birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. FATHER'S NAME		12. CITIZEN OF WHAT COUNTRY? USA	
William Hurt		Address	
13. MOTHER'S MAIDEN NAME		14. MOTHER'S MAIDEN NAME	
Anna Lee Braden		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT	
None		Ruth Crawford RN, Frederick County Chronic Hosp.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 15 mos.	
153.8 DUE TO Carcinoma Colon			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Mar 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/19</u> , 19 <u>60</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>H. F. Kline</u>		ADDRESS (Street, city or town, state) 7 N. Market St. DATE SIGNED 31 March 1960	
PHYSICIAN'S NAME (Type)		Frederick, Maryland	
H. F. Kline, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 4, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 5 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
part 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event within 72 hours after death,
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03243

3270

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 325 Reedwood Avenue		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) JOHN		First WILLIAM	Middle BRUCHHEY, SR.
4. DATE OF DEATH March 12, 1960		Last DEATH	Month March
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH February 8, 1898
9. AGE (In years (^{last} birthday) 62 yrs.)		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brushmaker		10b. KIND OF BUSINESS OR INDUSTRY Brush Co.	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles W. Bruchey	
14. MOTHER'S MAIDEN NAME Fannie Ainsworth		15. SOCIAL SECURITY NO. 214-10-2640	
16. INFORMANT Mrs. Helen M. Fox, Frederick, Maryland		17. 482 West ^{Ad} South Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH 2 months Generalized arterio-sclerosis 5 years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cerebral Thrombosis		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 2, 1948 to March 12, 1960 that I last saw the deceased alive on March 10, 1960 and that death occurred at 11:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) B. O. Thomas Jr.			
ACTUAL SIGNATURE		DATE SIGNED 3/15/60	
PHYSICIAN'S NAME (Type) B. O. Thomas, Jr., M.D.		M.D. Professional Building	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 16, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 18 '60	24b. REGISTRAR'S SIGNATURE Orlina S. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. 155ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03244

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		c. LENGTH OF STAY IN 1b 60 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont, rural RD 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Ernest	Middle Harvey	Last Carbaugh	4. DATE OF DEATH Month March Day 25 Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-30-1897	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0 IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Orchard		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Emanuel Carbaugh			14. MOTHER'S MAIDEN NAME Mary Ellen Connor		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 231-01-9322		17. INFORMANT Address Mrs. Wm. I. Sweeney Thurmont, Md. RD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (b) Exposure ONSET AND DEATH (a), stating the underlying cause lost. (c) months					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE B.O. Thomas	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED Mc. 25. 1960	
EXAMINER'S NAME (Type) B.O. Thomas					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-27-60	22c. NAME OF CEMETERY OR CREMATORIUM Lewistown Cemetery		22d. LOCATION (City, town, or county) Lewistown, Md. Fred. Co. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager	ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE MAR 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13
FOR STATE
HEALTH DEPT.

3271 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. STREET ADDRESS 508 Elm Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Richard	First Clare	Middle Cox	Last Month March Day 12 Year 19 60
4. DATE OF DEATH March 12, 1960	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH June 12, 1890	9. AGE (In years last birthday) 69 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Design Engineer	11. KIND OF BUSINESS OR INDUSTRY
12. BIRTHPLACE (State or foreign country) Mattoon, Illinois	13. CITIZEN OF WHAT COUNTRY? U.S.A.		
14. FATHER'S NAME Franklin Cox	15. MOTHER'S MAIDEN NAME Jenny Hughie		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	17. SOCIAL SECURITY NO. 097-14-2715	18. INFORMANT Mrs. Martha Cox (Wife) 508 Elm Street	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. B. O. Thomas, Sr.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 12, 1960
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-15-60	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) (State) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dudley Jr.	ADDRESS Frederick, Maryland	24a. REC'D BY REGISTRAR DATE MAR 16 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3307

CERTIFICATE OF DEATH

Reg. Dist. No.

03140

1. PLACE OF DEATH a. COUNTY	Frederick		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Cullen		345 days	c. LENGTH OF STAY IN 1b	Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	Victor Cullen State Hospital		345 days	d. STREET ADDRESS	900 Cathedral St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
M	W	Thompson	Darling	6-27-1960	3	17	1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	6-27-1905	54 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?					
Barber		Maryland	U.S.A.					
13. FATHER'S NAME	George Darling		14. MOTHER'S MAIDEN NAME	Linda Highmark				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address					
no	220-01-9561	Record of V. C. State Hospital						
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Pulmonary tuberculosis - 002					7 years		
002X	DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.	(b)							
	DUE TO							
	(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Arteriosclerosis - 420								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 4/9, 1959, to 3/17, 1960, that I last saw the deceased alive on 3/17, 1960, and that death occurred at 15 AM, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)					DATE SIGNED		
ACTUAL SIGNATURE	T. E. P. A. S. M.D.							
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Transf.	22b. DATE THEREOF 3/18/60	22c. NAME OF CEMETERY OR CREMATORIAL Board of Anatomy, U. of Md.	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Cullen - Thronton M.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Haas					
VS A15 (4) 15M 10/57								

MISSOURI STATE DEPARTMENT OF HEALTH - SANITATION

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Mar yland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont	
3. NAME OF DECEASED (Type or print) Wilbur Franklin Davis		First Wilbur	Middle Franklin
3. NAME OF DECEASED (Type or print) Wilbur Franklin Davis		Last Davis	4. DATE OF DEATH Month March 1, 1960 Day 19 Year 19
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Moore Bus. Forma	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME McClellan Davis		14. MOTHER'S MAIDEN NAME Sarah Yingling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-05-7302	17. INFORMANT Mrs. Geneva Davis
		Address Thurmont, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490 X		INTERVAL BETWEEN ONSET AND DEATH 6 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PROGRESSIVE MUSCULAR ATROPHY		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PROGRESSIVE MUSCULAR ATROPHY	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/27 , 19 60 , to 3/1 , 19 60 , that I last saw the deceased alive on 3/29 , 19 60 , and that death occurred at 1:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Richard C. Reynolds , M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Richard C. Reynolds		9 E. Church St. Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-4-60	22c. NAME OF CEMETERY OR CREMATORIUM Graceham Cemetery
22d. LOCATION (City, town, or county) Graceham		(State) Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		24a. REC'D BY REGISTRAR DATE MAR 3 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Main

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3273

CERTIFICATE OF DEATH

Reg. Dist. No.

03247

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 129 West Third Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Charlotte		First Trammell	Middle DeLashmutter
4. DATE OF DEATH March 2,		Last 1960	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 30, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Edward T. H. DeLashmutter		14. MOTHER'S MAIDEN NAME Emma Alvida Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-36-4174	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X		INFORMANT Miss Alvida DeLashmutter (Sister) 129 W. 3rd St. INTERVAL BETWEEN ONSET AND DEATH 3 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Hemorrhage		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) of	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE H. F. Kline		ADDRESS (Street, city or town, state) 7 North Market Street Frederick, Md.	
PHYSICIAN'S NAME (Type) Dr. H. F. Kline M.D.		DATE SIGNED 7-11-1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-1-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Robert E. Kline		24a. REC'D BY REGISTRAR Arthur S. Thomas	
ADDRESS Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3308

CERTIFICATE OF DEATH

Reg. Dist. No.

03248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Virginia Warren		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Rural- Middletown 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Front Royal 83X-3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Valley View Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First ORPHA	Middle SUSAN	Last DOMAN	4. DATE OF DEATH	Month March	Day 23	Year 1960
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1874	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Morgan McQuain		14. MOTHER'S MAIDEN NAME Julia Etta McQuain		INFORMANT		Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		Mrs W.R.Falkenstein, Myersville, Md.		17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While not while at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Feb 19, 1960</u> , to <u>Mar 23, 1960</u> , that I last saw the deceased alive on <u>Mar 23, 1960</u> , and that death occurred at <u>Middleton</u> , M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <u>Middleton</u> DATE SIGNED <u>3-25-60</u>		
ACTUAL SIGNATURE <u>J. Elmer Harp</u> M.D.								
PHYSICIAN'S NAME (Type) <u>J. Elmer Harp</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 27, 1960</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Asbury M. E.</u>		22d. LOCATION (City, town, or county) <u>Rock Oak, Hardy Co, W. Va.</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>		ADDRESS <u>Paul F. Bittle, Myersville, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03249

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

3309

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE MARYLAND c. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. AIRY R 2		c. LENGTH OF STAY IN 1b YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NEAR UNIONVILLE		d. STREET ADDRESS NEAR UNIONVILLE	
3. NAME OF DECEASED (Type or print) RICHARD MARLIN ECKER		First	Middle
4. DATE OF DEATH MARCH 5 1960		Lost	Month Doy Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 12-1909
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTING AND CARPENTERING		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
10c. BIRTHPLACE (State or foreign country) MARYLAND		11. AGE (In years from birthday) 50 yrs.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. IF UNDER 14 YEARS Months Days	14. IF UNDER 24 HRS. Hours Min.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-30-3025	
17. INFORMANT CHAS. J. ECKER MT. AIRY R 2 MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO coronary occlusion			
Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B.O. THOMAS		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) B.O. THOMAS		DATE SIGNED MAR. 5-1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/8/60	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS WINGANORE CEM. UNIONVILLE, MD		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas		24a. REC'D BY REGISTRAR DATE MAR 9 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

THE FEDERAL EXAMINER'S CERTIFICATE OF DEATH.

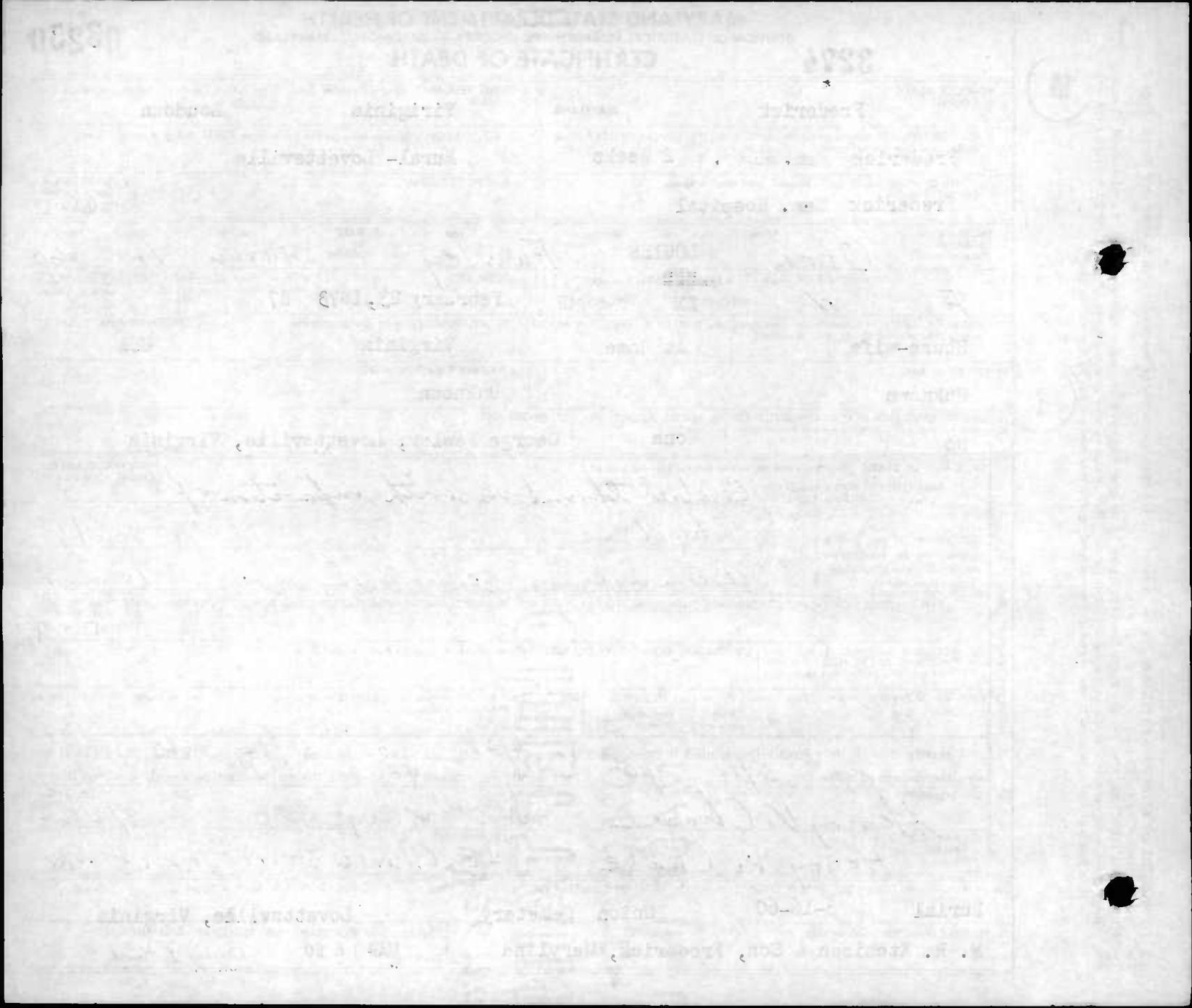
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3274 03250

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Virginia b. COUNTY Loudoun	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Mem. Hosp.		c. LENGTH OF STAY IN 1b 2 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Lovettsville	
e. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Orra		First LOUISE	Middle Fawley
4. DATE OF DEATH March 14 1960		Month March	Day 14
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. AGE (In years lost birthday) February 23, 1873		9. IF UNDER 1 YEAR Months 87 yrs.	10. IF UNDER 24 HRS. Hours 87 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT George Fawley, Lovettsville, Virginia		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis with infarction of INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 332X 2 hrs.			
(b) the brain, 10 yrs			
DUE TO (c) Arteriosclerosis, generalized, more			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/28 1960 to 3/14 1960 , that (I) (we) last saw the deceased alive on 3/14 1960 , and that death occurred at 4 P.M. from the causes and on the date stated above.		22b. DATE SIGNED 3/14/60	
22a. SIGNATURE Henry V. Chase		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 4 E. Church St Frederick Md
22c. PHYSICIAN'S NAME (Type) Henry V. Chase			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-16-60	23c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery
23d. LOCATION (City, town, or county) Lovettsville, Virginia		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	25a. REC'D BY REGISTRAR DATE MAR 18 '60
			25b. REGISTRAR'S SIGNATURE Charles S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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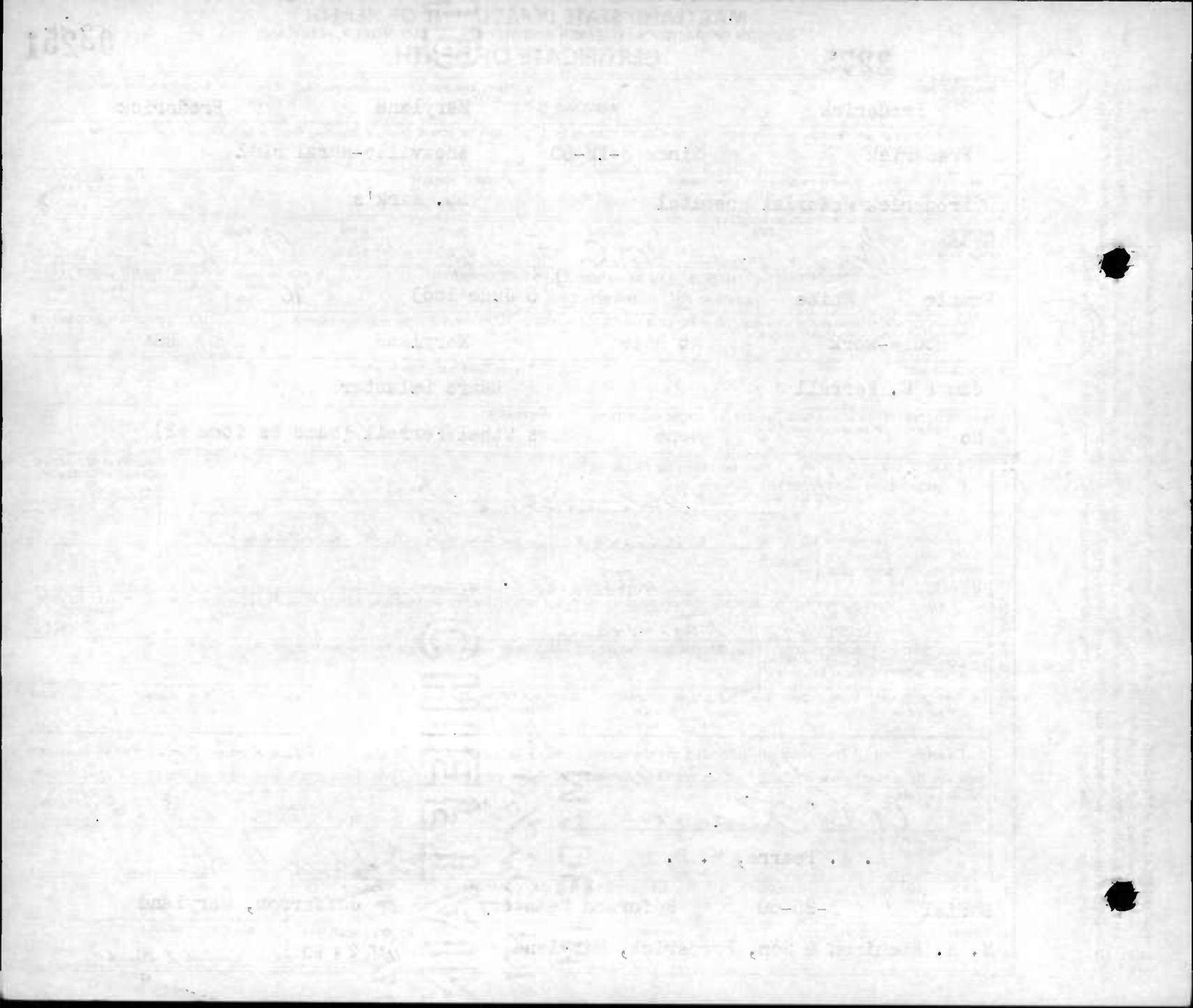
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03251

3275

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 3-18-60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Knoxville-Rural RD#1	
3. NAME OF DECEASED (Type or print) Miss Anna M. C. Ferrell		4. DATE OF DEATH March 22 1960	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 6 June 1883	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James C. Ferrell		14. MOTHER'S MAIDEN NAME Laura Delauter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Ethel Ferrell (Same as item #2)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Thrombosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) Frederick, Md		20f. (City or town) (County) Jefferson, Maryland (State)	
21. I certify that (I) (this hospital) attended the deceased from March 18 1960 to March 22 1960 , that (I) (we) last saw the deceased alive on March 22 1960 , and that death occurred at 7:30 PM , from the causes and on the date stated above.		22d. DATE SIGNED 3/22/60	
22a. SIGNATURE A. A. Pearre		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A. A. Pearre, M. D.		23d. LOCATION (City, town, or county) Jefferson, Maryland (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-26-60	
23c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		23d. LOCATION (City, town, or county) Jefferson, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		25a. REC'D BY REGISTRAR DATE MAR 24 '60	
ADDRESS		25b. REGISTRAR'S SIGNATURE Clinton S. Thorne	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03252

3295

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 West "B"		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick	
f. STREET ADDRESS 23 West "B"		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence		First Clarence	Middle Hamilton
		Last Foster	4. DATE OF DEATH 3 Month 23 Day Year 60 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-7-1899
9. AGE (In years less birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Foster		14. MOTHER'S MAIDEN NAME Annie Mewshaw	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT Mrs. Bessie V. Foster, Brunswick, Md.	
17. ADDRESS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } DUE TO Decompensated Congestive Heart Failure (b) Right Post-Pneumonia Hydrothorax } DUE TO (c) Coronary Insufficiency	
		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 30, 1957 , to March 23, 1960 , that I last saw the deceased alive on March 23, 1960 , and that death occurred at 6 A.M. from the causes and on the date stated above.		22. ACTUAL SIGNATURE  C. T. Byron Kao, M. D.	
		ADDRESS (Street, city or town, state) 15 S. Maryland Ave.	
23. PHYSICIAN'S NAME (Type) C. T. Byron Kao, M. D.		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-1960	
22c. NAME OF CEMETERY OR CREMATORIALY Union		22d. LOCATION (City, town, or county) Lovettsville, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. Lee Felt		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
		24b. REGISTRAR'S SIGNATURE Carling & Hause	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

103253

3275

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 6 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 109 West Third Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ELLA	Middle ESTELLE	Last FRY
4. DATE OF DEATH	Month March	Day 2,	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 4, 1874
9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	11. KIND OF BUSINESS OR INDUSTRY Domestic	12. BIRTHPLACE (State or foreign country) Virginia
13. FATHER'S NAME Joshua C. Fry	14. MOTHER'S MAIDEN NAME Maria Stout		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Miss M. Blanche Fry, (same as item #2)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x			
DUE TO Cerebral thrombosis			
INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Senility			
INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 7:40 , 19 59 to 3-2- , 19 60 that I last saw the deceased alive on 2-29 , 19 60 , and that death occurred at 7:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 North Market St.			
ACTUAL SIGNATURE <i>Rex R. Martin</i>	DATE SIGNED 3/3/60		
PHYSICIAN'S NAME (Type) Dr. Rex R. Martin	Frederick, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/4/60	22c. NAME OF CEMETERY OR CREMATORIUM Union Cemetery	22d. LOCATION (City, town, or county) (State) Lovettsville, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son; Frederick, Maryland	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 8 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Martin</i>

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03254

3277

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Life-Time	
d. NAME OF HOSPITAL (If not in hospital, give street address) 243 South Market Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) WILLIAM STEINER		First WILLIAM	Middle STEINER
Last GOSNELL		4. DATE OF DEATH March 28, 1960	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11 June 1881
9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Combination Man		10b. KIND OF BUSINESS OR INDUSTRY Telephone Company	
11. BIRTHPLACE (State or foreign country) Frederick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stewart Gosnell		14. MOTHER'S MAIDEN NAME Catherine Haugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-0806	
17. INFORMANT Mrs. Margaret D. Gosnell (Same as item #1)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/10 , 19 59 , to 3/28 , 19 60 , that I last saw the deceased alive on 3/28 , 19 60 , and that death occurred at 9:38 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard C. Reynolds</i>		ADDRESS (Street, city or town, state) 9 E. Church St. DATE SIGNED 30 March 1960	
PHYSICIAN'S NAME (Type) Richard C. Reynolds, M. D.		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-31-60	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS	
		24a. REC'D BY REGISTRAR DATE APR 1 '60	
		24b. REGISTRAR'S SIGNATURE <i>Carlo S. Knapp</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03255

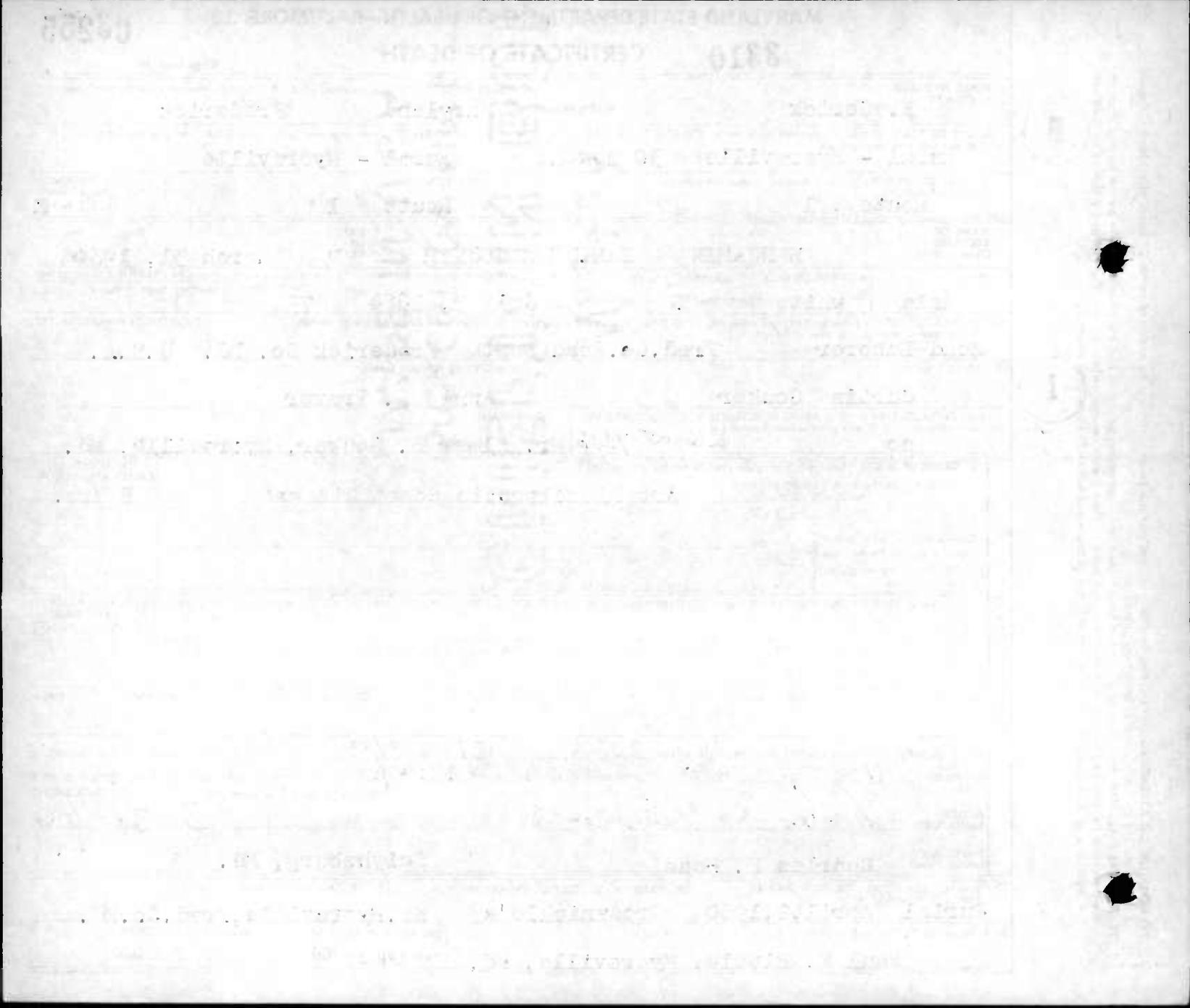
3310

CERTIFICATE OF DEATH

Reg. Dist. No.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Myersville		c. LENGTH OF STAY IN 1b 30 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BENJAMIN		First SAMEUL	Middle GOUKER
4. DATE OF DEATH March 31, 1960	Month Month	Day Days	Year Hours
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1884
9. AGE (In years lost birthday) 75 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Laborer	10b. KIND OF BUSINESS OR INDUSTRY Fred. Co. Road Dept	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Curtis Gouker		
14. MOTHER'S MAIDEN NAME Annie E. Traver	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 216-05-9216	17. INFORMANT Mr. Elmer B. Gouker, Myersville, Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 5 Yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/24, 1957, to 3/31, 1960, that I last saw the deceased alive on 3/20, 1960, and that death occurred at 11:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Charles F. Hess M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 2, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Grossnickle's
22d. LOCATION (City, town, or county) Nr. Myersville, Fred. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle, Myersville, Md.		24a. REC'D BY REGISTRAR DATE APR 5 '60	24b. REGISTRAR'S SIGNATURE Charles S. Kraus



18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

03256

3296											
1. PLACE OF DEATH a. COUNTY		Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		d. STREET ADDRESS 26 East "F"		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 26 East "F"				d. STREET ADDRESS 26 East "F"							
3. NAME OF DECEASED (Type or print)		First Emory	Middle Hamilton	Last Hahn	4. DATE OF DEATH	Month 3	Day 23	Year 1960			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-15-1893							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Town of Bswk.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Henry Hahn		14. MOTHER'S MAIDEN NAME Jennie Hamilton									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		INFORMANT		Address					
				Mrs. Lillie M. Hahn, Brunswick, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
421.4 DUE TO <i>Valvular Heart Disease</i>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)											
DUE TO <i>Thrombotic</i> (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				19							
21. I certify that I attended the deceased from <i>11/24/60</i> to <i>12/23/60</i> , and that death occurred at <i>12:00 A.M.</i> on <i>12/23/60</i> , at <i>Brunswick, Maryland</i> , from the causes and on the date stated above.											
ACTUAL SIGNATURE <i>J.G.F. Smith</i>		PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) Park Heights		M.D.		DATE SIGNED <i>12/23/60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-25-1960		22c. NAME OF CEMETERY OR CREMATORIUM Park Heights		22d. LOCATION (City, town, or county) Brunswick, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Lee Felt</i>		ADDRESS Brunswick, Maryland				24a. REC'D BY REGISTRAR DATE MAR 28 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

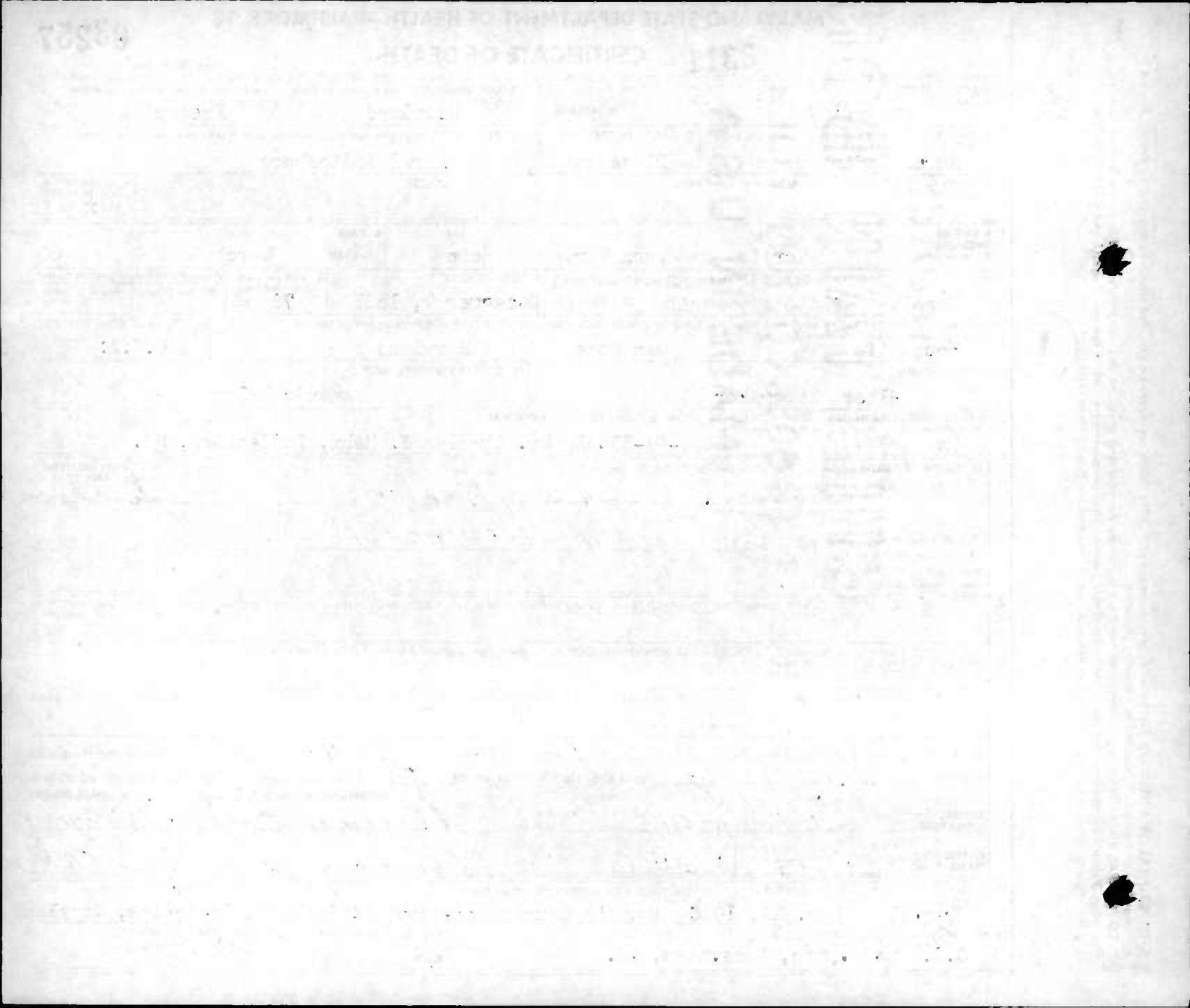
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

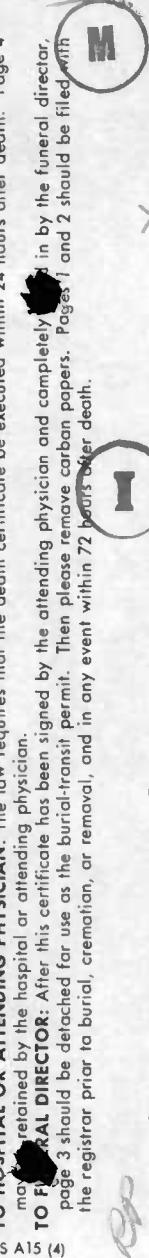
03257

3311 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ladiesburg		b. COUNTY Frederick	
c. LENGTH OF STAY IN 1b 21 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Ladiesburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Vertie		First Anna	Middle Mary
Last Hahn		4. DATE OF DEATH March	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH December 7, 1881		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. / / / /
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert Shoemaker		14. MOTHER'S MAIDEN NAME Amanda Eyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-01-3184B	INFORMANT Mr. Charles F. Hahn, Ladiesburg, Md.
17. MEDICAL CERTIFICATION		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2-16, 1960, to 3-9-, 1960 that I last saw the deceased alive on 3-7, 1960, and that death occurred at 7 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) J. N. Legg M.D. 3-11-60	
ACTUAL SIGNATURE T. H. Legg		DATE SIGNED 3-11-60	
PHYSICIAN'S NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Mar. 12, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Haugh's Church Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son, Taneytown, Md.		22d. LOCATION (City, town, or county) Ladiesburg, Frederick, Maryland	
ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Knue





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03258

3312

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown		c. LENGTH OF STAY IN lb years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middletown	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Elva Mae Hoffman		4. DATE OF DEATH Month 3 Day 12 Year 1960	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 5/26/1925	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 34 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bookkeeper	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George A. Bidle		14. MOTHER'S MAIDEN NAME Goldie Guyton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-20-9491	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INFORMANT Harold H. Hoffman, Middletown, Md.	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (masectomy performed in 1956)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 12 , 1958, to Mar 12 , 1960, that I last saw the deceased alive on Mar 12 , 1960, and that death occurred at Middle , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Elmer Harp</i>		ADDRESS (Street, city, or town, state) Middletown, Md.	
PHYSICIAN'S NAME (Type) Dr. J. Elmer Harp		DATE SIGNED 3-14-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 3/15/1960	
22c. NAME OF CEMETERY OR CREMATORIAL U.B. Cemetery		22d. LOCATION (City, town, or county) Myersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE MAR 16 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3297

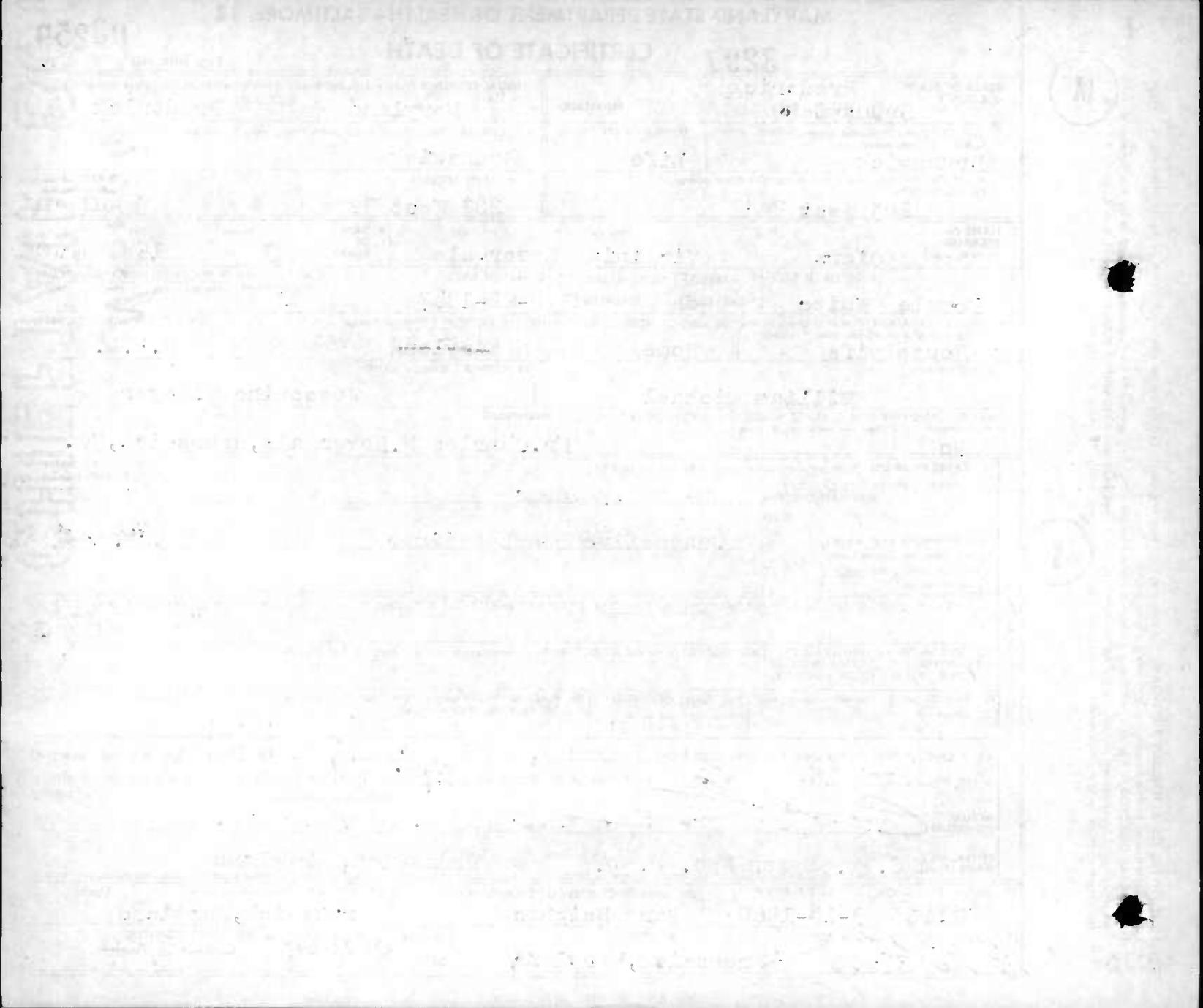
CERTIFICATE OF DEATH

Reg. Dist. No.

03259

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Frederick 99999999999		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland		b. COUNTY		Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brunswick		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 35 Brunswick		d. STREET ADDRESS		203 West "B"		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 203 West "B"													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH		Month	Day	Year				
Female		Clara	Virginia	Hovermale	3	15	19	60					
S. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)		IF UNDER 1 YEAR	IF UNDER 24 HRS					
Female		White	WIDOWED <input checked="" type="checkbox"/>	8-22-1867	92	yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) WEST Maryland		12. CITIZEN OF WHAT COUNTRY? VIRGINIA U.S.A.							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
William Michael		Josephine Widnyer											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address							
No				Mr. Charles W. Hovermale, Brunswick, Md.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema													
434.1 DUE TO													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure													
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I attended the deceased from March 7, 1960, to March 15, 1960, that I last saw the deceased alive on March 15, 1960, and that death occurred at 5:15 AM, from the causes and on the date stated above.													
ACTUAL SIGNATURE:  ADDRESS (Street, city or town, state) 15 S. Maryland Ave., M.D.													
DATE SIGNED													
PHYSICIAN'S NAME (Type)		C. T. Byron Kao, M. D.		Brunswick, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-18-1960		22c. NAME OF CEMETERY OR CREMATORIAL Park Heights		22d. LOCATION (City, town, or county) Brunswick, Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS Brunswick, Maryland				24a. REC'D BY REGISTRAR MAR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan					
						DATE							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03260

3278

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b over 35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 509 Lee Place		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print) Grace		First Corbitt	Middle Keyes
4. DATE OF DEATH March 15,		Last	Month Year Day Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 16, 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	9. AGE (In years last birthday) 72 yrs.
13. FATHER'S NAME George Andrew Bishop Zimmerman	14. MOTHER'S MAIDEN NAME Ida Belle Corbitt	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-34-0815	INFORMANT Miss Dorothy E. Keys	Address 509 Lee Place
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Breast</i> DUE TO <i>170X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 18 mos
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 29, 1958</i> , to <i>March 15, 1960</i> , that I last saw the deceased alive on <i>March 15, 1960</i> , and that death occurred at <i>6:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>S. Schoolman</i>	M.D.	ADDRESS (Street, city or town, state) <i>228 North Market St.</i>	DATE SIGNED <i>March 15, 1960</i>
PHYSICIAN'S NAME (Type) Dr. J. R. Schoolman	N.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 3-18-1960	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland	
23. FUNERAL/DIRECTOR'S SIGNATURE <i>Robert E. Dailey Jr.</i>	ADDRESS Frederick, Maryland	24a. REC'D BY REGISTRAR DATE MAR 16 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03261

3313 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#7		c. LENGTH OF STAY IN 1b Since 5-12-58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montevue (County Home)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle EDWARD
Last KINTZ		4. DATE OF DEATH March 20, 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 Sept 1879
10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years last birthday) 80 yrs.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME David Kintz	
14. MOTHER'S MAIDEN NAME Ida Whipp		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Unk		INFORMANT Harry Kintz, RD#1, Adamstown, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 17</u> , 1960, to <u>Mar 17</u> , 1960, that I last saw the deceased alive on <u>Mar 17</u> , 1960, and that death occurred at <u>5:30A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>H. F. Kline</u> ADDRESS (Street, city or town, state) M.D. 7 N. Market St. DATE SIGNED 21 March 1960			
PHYSICIAN'S NAME (Type) H. F. Kline, M. D.		Frederick, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-60	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 23 '60	24b. REGISTRAR'S SIGNATURE Clyde S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TELEGRAMS: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the funeral director prior to burial, cremation, or removal.

VS. A1SME(5)
5M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3314 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		c. LENGTH OF STAY IN 1b years		d. STATE Maryland b. COUNTY Frederick	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Burkittsville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Ella		First	Middle	Last	4. DATE OF DEATH Month Day Year 3 14 1960
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9/9/1870	9. AGE (In years at birthday) 89	10. IF UNDER 1 YEAR yrs. <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME (unknown) Young			
14. MOTHER'S MAIDEN NAME Savilla King		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. none		17. INFORMANT Fred. Co. Welfare Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) bronchial pneumonia 491X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) exposure DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE B. O. Thomas		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 3/14/1960	
EXAMINER'S NAME (Type) Dr. B. O. Thomas		22a. BURIAL, CREMATION, REMOVAL (Specify) burial 22b. DATE THEREOF 3/17/1960 22c. NAME OF CEMETERY OR CREMATORIAL CH. OF G. Cem., Frederick Co., Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Company, Middletown, Md.		24a. REC'D BY REGISTRAR DATE MAR 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enter the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG259 3-28-60 et

3316

CERTIFICATE OF DEATH

Reg. Dist. No.

03264

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville		c. LENGTH OF STAY IN 1b 35 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unionville	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS /	
3. NAME OF DECEASED (Type or print) LEONA		First A.	Middle LONG
4. DATE OF DEATH Month March		Last 16,	Day Year 19 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		9. AGE (In years lost birthday) 74 yrs.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Long	
14. MOTHER'S MAIDEN NAME Martha Black		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 216-22-9845		INFORMANT Myrthe Long	Address Same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 5 days Coronary Thrombosis Coronary Sclerosis 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June , 19 55 , to March , 19 60 , that I last saw the deceased alive on March 16, 19 60 , and that death occurred at 11 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. B. Culwell		M.D. 900 So. Main	ADDRESS (Street, city or town, state) Mt. Airy, Md
PHYSICIAN'S NAME (Type) W. B. Culwell		DATE SIGNED 3/17/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-21-1960	22c. NAME OF CEMETERY OR CREMATORIAL Linganore Cemetery
22d. LOCATION (City, town, or county) Frederick Co. Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. WALTZ, Winfield, Maryland		24a. REC'D BY REGISTRAR DATE MAR 22 '60	24b. REGISTRAR'S SIGNATURE Irving S. Kraus

DEPARTMENT OF THE NAVY - 1971 EDITION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03265

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY FREDERICK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY <i>Fred.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>FREDERICK, MARYLAND</i>		c. LENGTH OF STAY IN 1b LIFETIME	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FREDERICK MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL FREDERICK, Route #2	
3. NAME OF DECEASED (Type or print) HELEN		First HELEN	Middle VIRGINIA
Last MAIN		4. DATE OF DEATH Month March Day 26 Year 1960	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1915
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. KIND OF BUSINESS OR INDUSTRY Homemaker
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Elmer Shelton	
14. MOTHER'S MAIDEN NAME Mary Siers.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 215-34-2578		17. INFORMANT Mar. Hattie	18. ADDRESS Shelton, Frederick Rt #2.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Frederick	(County) Md.	(State) MD.	
21. I certify that I attended the deceased from 3-24 , 1962 to 3-26 , 1962, that I last saw the deceased alive on 3-25 , 1962, and that death occurred at 10:35 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>U. G. Bourne Jr.</i>	M.D.	ADDRESS (Street, city or town, state) 30, All Saints St., Frederick, Maryland.	DATE SIGNED 3-26-60
PHYSICIAN'S NAME (Type) U. G. Bourne	22d. LOCATION (City, town, or county) Frederick, Maryland. (State)		
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 31-29-60	22c. NAME OF CEMETERY OR CREMATORIUM Mt Olivet Cemetery	22d. LOCATION (City, town, or county) Frederick, Maryland. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. E. Dailey Jr.</i> DAILEY'S FUNERAL HOME		24a. ADDRESS FREDERICK, MARYLAND,	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>
		24a. REC'D BY REGISTRAR DATE MAR 30 '60	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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HEAD TO THE UNITED STATES

RECEIVED - 1941

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03266

3280

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK		First FRANK	Middle JEROME
4. DATE OF DEATH March 9, 1960		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH August 5, 1903	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) County Rd. Dept.		10b. KIND OF BUSINESS OR INDUSTRY Grader Operator	
11. BIRTHPLACE (State or foreign country) Maryland		12. MOTHER'S MAIDEN NAME Katherine Pearre	
13. FATHER'S NAME Joseph McClain		14. MOTHER'S MAIDEN NAME Katherine Pearre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-14-6781 17. INFORMANT Mrs. Frances Irene McClain—Same as item #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION		Address INTERVAL BETWEEN ONSET AND DEATH Minutes	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Hyattstown (County) Maryland (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>		DATE SIGNED 3/11/1960	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 12, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Methodist Cemetery	22d. LOCATION (City, town, or county) (State) Hyattstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. L. Burdette, Hyattstown, Maryland		24a. REC'D BY REGISTRAR DATE MAR 14 '60 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03267

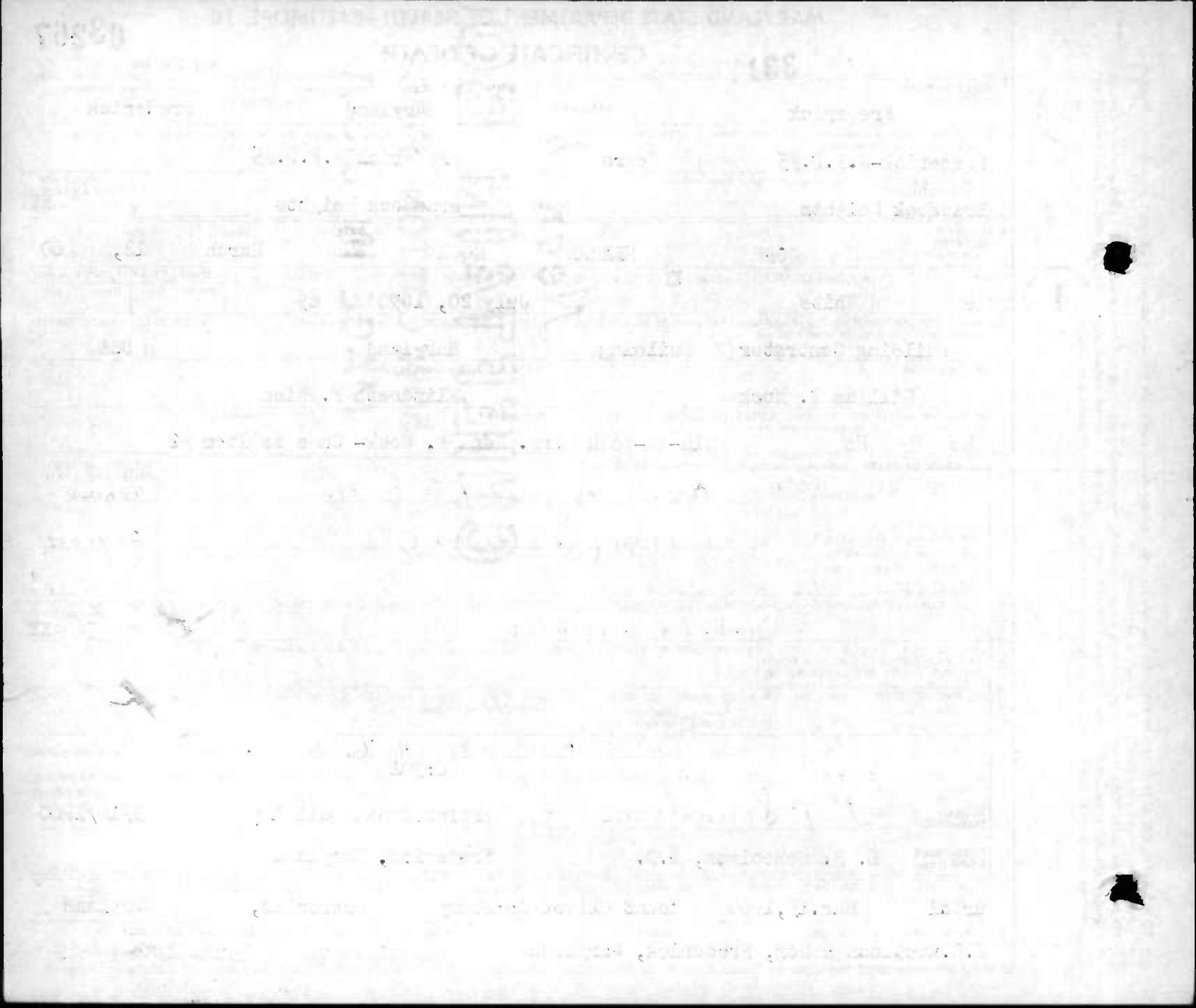
CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-R.F.D.#5		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Braddock Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick R.F.D.#5	
3. NAME OF DECEASED (Type or print) JOHN		First HERMAN	Middle MOCK
4. DATE OF DEATH March 12, 1960		Month March	Day 12 , Year 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 20, 1890		9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS. Days 0	13. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Building Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	
13. FATHER'S NAME William T. Mock		14. MOTHER'S MAIDEN NAME Elizabeth F. Wise	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-14-6674	
17. INFORMANT Mrs. Edna R. Mock—Same as Item #2		18. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Coronary Sclerosis (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1/2 hour 21 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct , 19 37 , to March 12 , 19 60 , that I last saw the deceased alive on March 12, 1960 , and that death occurred at 6:30A M, from the causes and on the date stated above. ACTUAL SIGNATURE S. R. Schoolman		ADDRESS (Street, city or town, state) Professional Building DATE SIGNED 3/14/1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, (State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, Frederick, Maryland		ADDRESS M.R. Etchison & Son, Frederick, Maryland	24a. REC'D BY REGISTRAR DATE MAR 15 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3299

CERTIFICATE OF DEATH

03268

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		c. LENGTH OF STAY IN 1b 35 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Main Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		d. STREET ADDRESS East Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) George		First	Middle	Last	4. DATE OF DEATH March	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH Oct. 30, 1873	9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) York Springs, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry A. Naylor		14. MOTHER'S MAIDEN NAME Margaret L. RHODES		Address Taneytown, Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-1054		17. INFORMANT G. Willur Naylor		INTERVAL BETWEEN ONSET AND DEATH 1 day			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Acute myocardial failure -				5 yrs			
(b) DUE TO cause (a), stating the under- lying cause last.		myocardial degeneration				arterio sclerotic C.V. disease - several years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. p. 19 p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Emmitsburg, Md.	(County)	(State)			
21. I certify that I attended the deceased from <u>Dec.</u> , 19 <u>60</u> , to <u>March 27, 1960</u> , that I last saw the deceased alive on <u>March 27, 1960</u> , and that death occurred at <u>4A</u> M., from the causes and on the date stated above.		ACTUAL SIGNATURE W. R. Cadle		ADDRESS (Street, city or town, state) Emmitsburg, Md.		DATE SIGNED 3-28-60			
PHYSICIAN'S NAME (Type) Dr. W. R. Cadle									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/30/60	22c. NAME OF CEMETERY OR CREMATORIUM Keysville Cemetery	22d. LOCATION (City, town, or county) Keysville, Md.	(State) Carroll Co.					
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.	24a. REC'D BY REGISTRAR DATE MAR 31 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					
C. E. Wilson									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician and completely in by the funeral director. Page 1
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 3281 CERTIFICATE OF DEATH 03269

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. STREET ADDRESS 400 Middle Alley	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harriet Cornelious Naylor (Hattie)		First Harriet	Middle Cornelious
4. DATE OF DEATH March 2 1960		Month March	Day 2
5. SEX F		6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 1909		9. AGE (In years lost birthday) 51 yrs.	10. IF UNDER 1 YEAR Months 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Frederick-Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Henry Naylor		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Nellie Holland-15 W. All Saints St.		Address Fred. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0		INTERVAL BETWEEN ONSET AND DEATH 2 years 1 day.	
DUE TO Sirrhosis Liver (Hepatic Cirrhosis)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 20 , 19 60 , to March 2 , 19 60 , that I last saw the deceased alive on March 2 , 19 60 , and that death occurred at 8 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Bernard O. Thomas, Jr.</i>		ADDRESS (Street, city or town, state) Frederick, Md. DATE SIGNED March 7, 1960	
PHYSICIAN'S NAME (Type) BERNARD O. THOMAS, JR. FREDERICK, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-60	
22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls		22d. LOCATION (City, town, or county) Della-Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hucks 111		ADDRESS Frederick-Md.	
24a. REC'D BY REGISTRAR MAR 11 1960		24b. REGISTRAR'S SIGNATURE Edward S. Francis	

48961

1943-50 BUDGETED

1943-50

1943-50

1943-50

1943-50 BUDGETED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03270

3300

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,		c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Main Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Emmitsburg,			
3. NAME OF DECEASED (Type or print) First Maud		d. STREET ADDRESS East Main Street			
4. DATE OF DEATH March 27,		Month 19	Day 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 27, 1878		
8. AGE (In years lost birthday) 81		9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home			
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Benjamin R. Stull		14. MOTHER'S MAIDEN NAME Estelle Whitmore			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No		16. SOCIAL SECURITY NO. None			
17. INFORMANT sg Wilmer Naylor		Address Taneytown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		INTERVAL BETWEEN ONSET AND DEATH 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO arterio & atherosclerotic cardio vas disease - several years		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. p.m. 19	20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Emmitsburg, Md.	(County)	(State)
21. I certify that I attended the deceased from <u>Dec</u> , 19 <u>60</u> to <u>March 27, 1960</u> , that I last saw the deceased alive on <u>March 27, 1960</u> , and that death occurred at <u>1901</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Emmitsburg, Md.		DATE SIGNED March 28, 60			
ACTUAL SIGNATURE W. R. Cadle					
PHYSICIAN'S NAME (Type) Dr. W. R. Cadle		Emmitsburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/30/1960	22c. NAME OF CEMETERY OR CREMATORIAL Keysville Cemetery	22d. LOCATION (City, town, or county) Keysville, Md.	(State) Carroll Co.
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Wilson		ADDRESS Emmitsburg, Md.		24a. REC'D BY REGISTRAR DATE MAR 31 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

3282

03271

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

FREDERICK MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Frederick

c. LENGTH OF STAY IN 1b

10 hrs 35 min

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Frederick Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

MARYLAND

b. COUNTY

FREDERICK

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

11 153 W. All Saints St.

d. STREET ADDRESS

Frederick Maryland

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

Kenneth

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

MAR

13

1960

5. SEX

M

6. COLOR OR RACE

N

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

MARCH 13, 1960

9. AGE (In years
last birthday)
yrs.

10

10. IF UNDER 1 YEAR
IF UNDER 24 HRS.

Months Days Hours Min.

10 35

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Maryland

U.S.A.

13. FATHER'S NAME

SAMUEL RAY PALM

14. MOTHER'S MAIDEN NAME

MILDRED WHITING NAYLOR

Address

MOTHER 153 W. ALL SAINTS ST.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

INTERVAL BETWEEN
ONSET AND DEATH

hour

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Congestive Heart Failure, cause unclear.

2. MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 13 March 1960, to 13 March 1960, that (I) (we) last
saw the deceased alive on 13 March 1960, and that death occurred at 13 March 1960, from the causes and on the date stated above.

22a. SIGNATURE

A. M. Powell Jr.

M.D. ATTENDING
PHYS.MED.
DIRECTOR STAFF
PHYS. 22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

A. M. Powell Jr.

22d. ADDRESS

Frederick-Medical-Center
Maryland23a. BURIAL, CREMATION,
REMOVAL (Specify)

BURIAL

23b. DATE THEREOF

MAR 15 '60

23c. NAME OF CEMETERY OR CREMATORI

FAIRVIEW

23d. LOCATION (City, town, or county)

Frederick - Md.

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

C. E. Hicks III

ADDRESS

Frederick - Md.

25a. REC'D BY REGISTRAR

DATE MAR 17 '60

25b. REGISTRAR'S SIGNATURE

Arthur S. Kline

13
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3318 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03272

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural-R.D.#5		c. LENGTH OF STAY IN 1b 2 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Rural -R.F.D.#5	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Fulmer Road				d. STREET ADDRESS Fulmer Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ARCHIE		First LEE	Middle PERSSON	Lost PERSSON	4. DATE OF DEATH March 25, 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH January 1, 1892	9. AGE (In years less birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? If yes, no, or unknown Yes WWI		16. SOCIAL SECURITY NO. 216-12-4613		17. INFORMANT Mrs. Viola M. Davis, 333rd South Market Street, Frederick, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) DUE TO		CORONARY THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH Minutes ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>B. O. Thomas</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED March 25, 1960	
EXAMINER'S NAME (Type) B. O. Thomas, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 28, 1960		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery	
22d. LOCATION (City, town, or county) Frederick,				(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAR 29 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 Items 11,12 **CERTIFICATE OF DEATH** Film G259, 3/24/60b

03273

3283		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)							
1. PLACE OF DEATH a. COUNTY		b. STATE							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
d. NAME OF HOSPITAL (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
e. INSTITUTION		f. STREET ADDRESS							
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		NOV. 30 1893		66 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
SALESMAN		LIFE INSURANCE		New York City		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
JOSEPH PLANT		MARY MATHONLEY		Mrs. JOSEPH PLANT		Address		Mrs. JOSEPH PLANT Rochester N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH		+ hr.	
420.0		DUE TO		Arteriosclerotic heart disease		DUE TO		10 yrs +	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)		(c)		DUE TO		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		Diabetes mellitus		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
20c. TIME OF INJURY Hour a. m. p. m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	
21. I certify that (I) (this hospital) attended the deceased from 3/19 1960, to 3/20 1960, that (I) (we) last saw the deceased alive on 3/20 1960, and that death occurred at 3A M, from the causes and on the date stated above.		22a. SIGNATURE		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)		Henry V. Chase		22d. ADDRESS		3/20/60			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORI		23d. LOCATION (City, town, or county)		(State)	
Burial		3/24/60		Holy Sepulcher		Rochester		N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Clarence C. Early		Frederick		DATE		MAR 21 '60		Arthur S. Kline	

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03274

3284

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 weeks 3		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont -- rural		d. STREET ADDRESS Creagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle F	Last PLUMER	4. DATE OF DEATH	Month 3	Day 15	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 29, 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Plumer		14. MOTHER'S MAIDEN NAME Margaret Snyder		Address Thurmont, Md. RFD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 217-12-1801		17. INFORMANT Louis Plumer		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Generalized arteriosclerosis (c) DUE TO Cerebral thromboses	
						INTERVAL BETWEEN ONSET AND DEATH 36 days	
						years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/6 19 60 to 3/15 19 60 , that (I) (we) last saw the deceased alive on 3/15 19 60 and that death occurred at 11:30 AM , from the causes and on the date stated above.		22a. SIGNATURE Richard C. Reynolds		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/16/60	
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds		22d. ADDRESS 9 E. Church St. Frederick, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-18-60		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel Cemetery		23d. LOCATION (City, town, or county) (State) Thurmont, Md. Fred. Co.	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond G. Bryan		ADDRESS Thurmont, Md.		25a. REC'D BY REGISTRAR DATE MAR 21 '60		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3319

CERTIFICATE OF DEATH

Reg. Dist. No.

03275

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 be retained by the hospital or attending physician.

GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thurmont rural		c. LENGTH OF STAY IN lb 30 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Own Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Thurmont rural creagerstown	
e. STREET ADDRESS 1		f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth M. Plumer		First Elizabeth	Middle M.
4. DATE OF DEATH March 1, 1960	Month March	Day 1	Year 1960
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1888
9. AGE (In years (last birthday) 71 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Louis Plumer		Address Thurmont, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 481X DUE TO Acute pulmonary edema INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Myocardial insufficiency 4 years (c) DUE TO Bronchitis and virus influenza 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 26, 1960 , to Mar 1, 1960 , that I last saw the deceased alive on Mar 1, 1960 , and that death occurred at 445 M., from the causes and on the date stated above.			
ACTUAL SIGNATURE James K. Gray		ADDRESS (Street, city or town, state) Thurmont, Md. DATE SIGNED 3/2/60	
PHYSICIAN'S NAME (Type) James K. Gray		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 3-4-60	
22b. DATE THEREOF 3-4-60		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Cemetery	
22d. LOCATION (City, town, or county) Thurmont, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	
24a. REC'D BY REGISTRAR DATE MAR 7 '60		24b. REGISTRAR'S SIGNATURE Julia S. Thomas	

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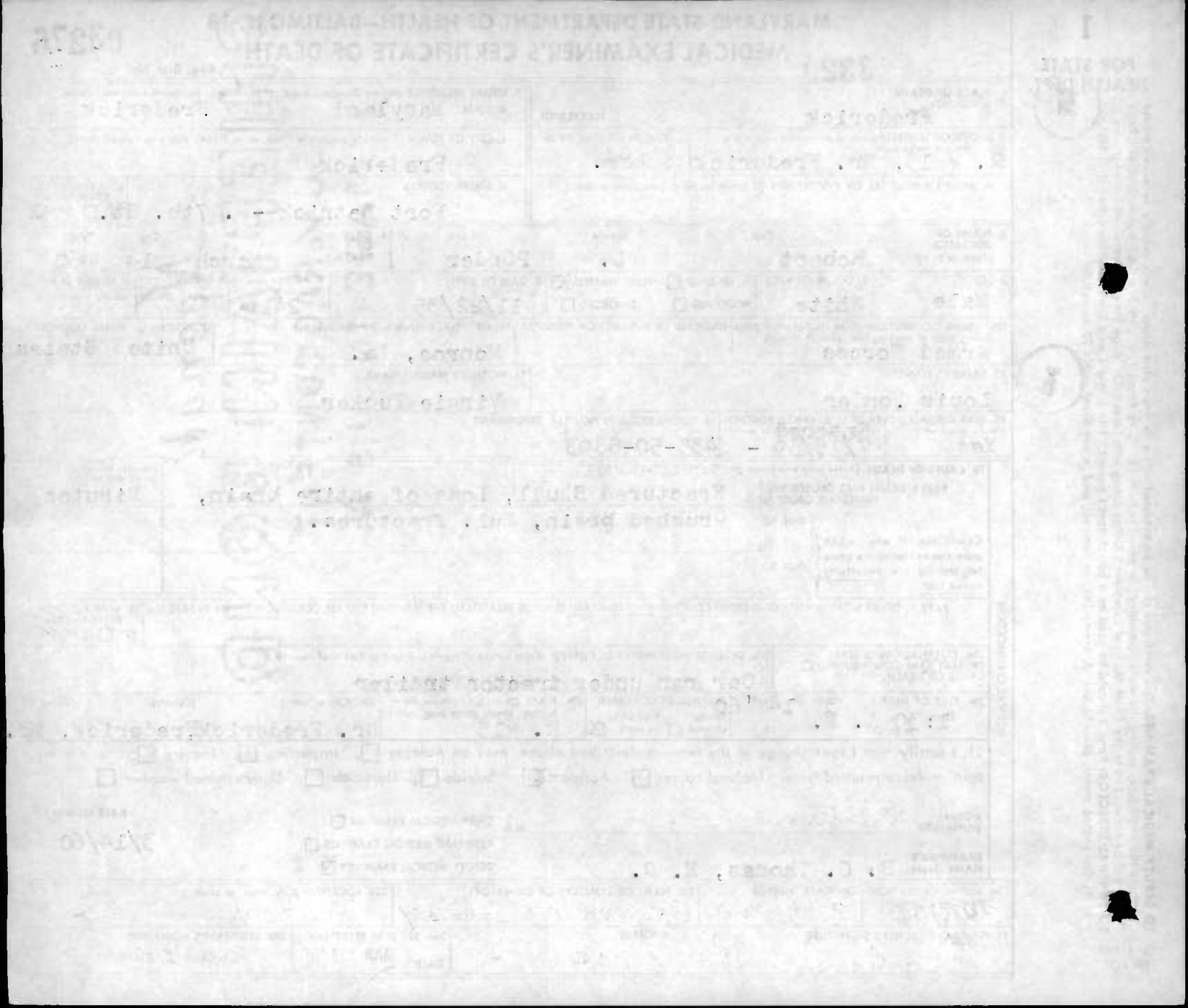
1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03276

FOR STATE
HEALTH DEPT.

1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 2 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3320		Reg. Dist. No.											
<p>1. PLACE OF DEATH a. COUNTY Frederick MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. # 15, Nr. Frederick</p> <p>c. LENGTH OF STAY IN 1b 6 mos.</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)</p>					<p>2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick</p> <p>d. STREET ADDRESS Fort Detrick - W. 7th. St.</p>					<p>e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) Robert</p> <p>First L. Middle P Onder</p>		<p>4. DATE OF DEATH March 14 1960</p>		<p>Month March Doy 14 Year 1960</p>									
<p>5. SEX Male</p> <p>6. COLOR OR RACE White</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 11/22/35</p>		<p>9. AGE (In years last birthday) 24 yrs.</p>		<p>IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0</p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Armed Forces</p>					<p>10b. KIND OF BUSINESS OR INDUSTRY</p>					<p>11. BIRTHPLACE (State or foreign country) Monroe, La.</p>			
<p>13. FATHER'S NAME Louis Ponder</p>					<p>14. MOTHER'S MAIDEN NAME Virgie Tucker</p>					<p>12. CITIZEN OF WHAT COUNTRY? United States</p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input checked="" type="checkbox"/> Entered <input type="checkbox"/> Discharged <input type="checkbox"/> (Name and date of service) Yes 7/16/59 -</p>					<p>16. SOCIAL SECURITY NO. 435-50-8803</p>					<p>Address</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 816X DUE TO Fractured Skull, Loss of entire brain, Minutes</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed brain, Mul. fractures.</p> <p>DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car ran under tractor trailer</p> <p>20c. TIME OF INJURY Month Mar. Day 14 Year 60 20d. INJURY OCCURRED White Not white <input type="checkbox"/> of work <input type="checkbox"/> of work R. #15 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Nr. Frederick (County) Frederick, Md. (State)</p> <p>20g. (Time) 1:30 A. M. 20h. (Date) 19</p>												<p>19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>													
<p>ACTUAL SIGNATURE B. O. Thomas</p>		<p>M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>											
<p>EXAMINER'S NAME (Type) B. O. Thomas, M. D.</p>		<p>DATE SIGNED 3/14/60</p>											
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL</p>		<p>22b. DATE THEREOF 3/18/1960</p>		<p>22c. NAME OF CEMETERY OR CREMATORIUM GREENWOOD CEMETERY</p>		<p>22d. LOCATION (City, town, or county) RUSTON (State) LA.</p>							
<p>23. FUNERAL DIRECTOR'S SIGNATURE G. Marie Boe, WAYNESBORO, PA.</p>		<p>ADDRESS</p>		<p>24a. REC'D BY REGISTRAR Arthur S. Krause</p>		<p>24b. REGISTRAR'S SIGNATURE</p>							
<p>VS. A15ME SM 2/57</p>		<p>DATE MAR 17 '60</p>											



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FOR STATE
HEALTH DEPT.
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2
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03277

Reg. Dist. No.

3321

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rose Marinos Restaurant-Rt. 240A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James Keefer		First James	Middle Keefer
4. DATE OF DEATH March 2, 1960	Month March	Day 2	Year 1960
5. SEX Male	6. COLOR OR RACE Ne gro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 10- 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook	10b. KIND OF BUSINESS OR INDUSTRY *****	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Proctor		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Merhle Proctor-5843 Cedar Ave. Phila. Pa.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 49 IX DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>B. O. Thomas</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) B. O. Thomas, Sr., M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-6-60	22c. NAME OF CEMETERY OR CREMATORIAL Fairyview	22d. LOCATION (City, town, or county) Frederick, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Hicks 111		ADDRESS Frederick, Maryland	24a. REC'D BY REGISTRAR DATE MAR 7 '60
			24b. REGISTRAR'S SIGNATURE Arthur S. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

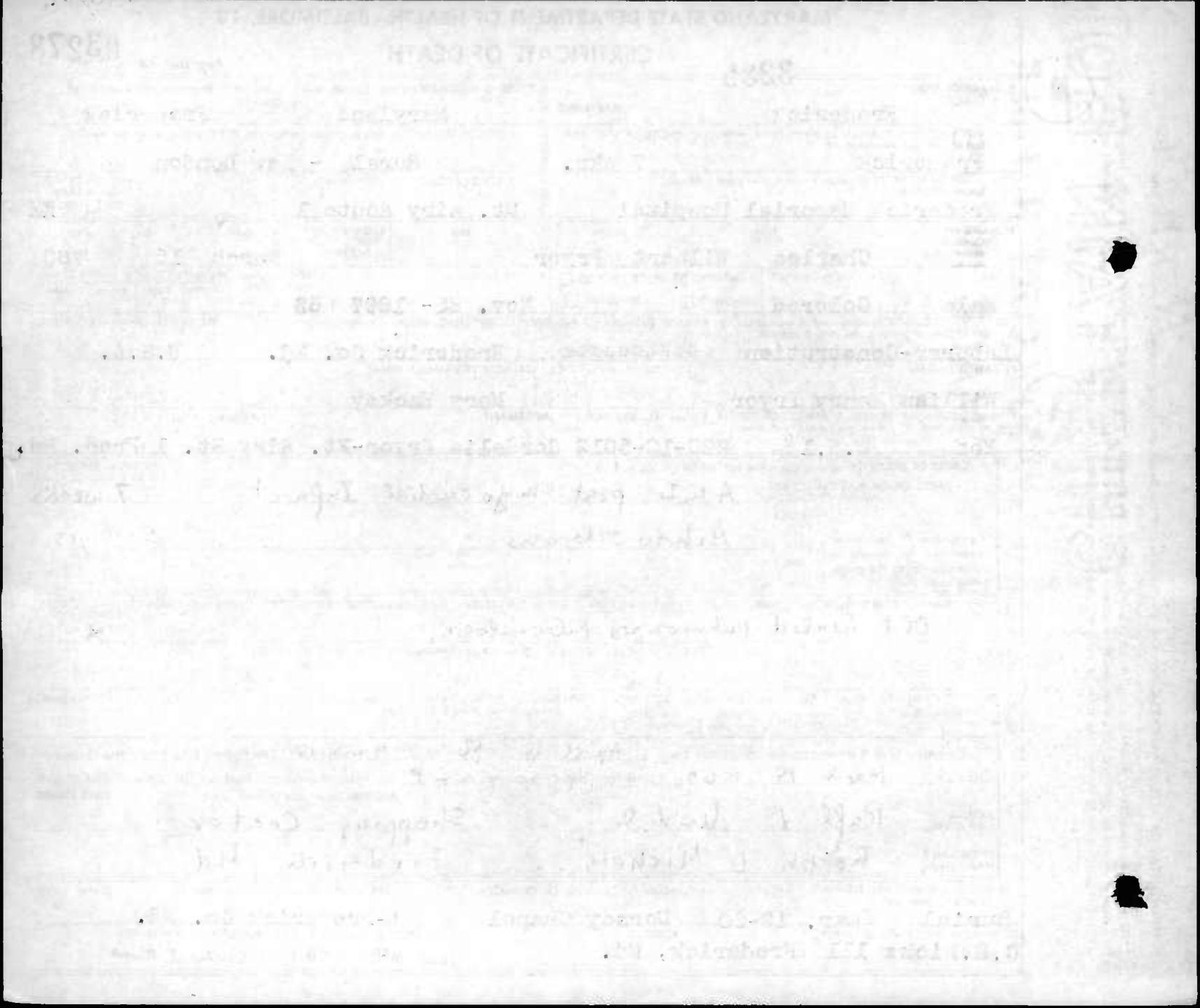
CERTIFICATE OF DEATH

Reg. Dist. No.

03278

3285

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Frederick MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 7 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - New London	
3. NAME OF DECEASED (Type or print)		First	Middle
Charles Wilbert Pryor		Lost	4. DATE OF DEATH
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	Colored		Nov. 25- 1896 63
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Construction		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Henry Pryor		14. MOTHER'S MAIDEN NAME Mary Hackey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220-10-5012	
INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis (c)		INTERVAL BETWEEN ONSET AND DEATH 7 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old healed pulmonary tuberculosis.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 18, 1956, to March 15, 1960, that I last saw the deceased alive on March 15, 1960, and that death occurred at 2 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph L. Michels		ADDRESS (Street, city or town, state) Shopping Center Frederick, Md.	
PHYSICIAN'S NAME (Type) Ralph L. Michels		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19-60	
22c. NAME OF CEMETERY OR CREMATOR Y Dorsey Chapel		22d. LOCATION (City, town, or county) Frederick Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks 111		ADDRESS Frederick, Md.	
24a. REC'D BY REGISTRAR DATE MAR 17 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3286

CERTIFICATE OF DEATH

Reg. Dist. No.

03279

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 3 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> d. STREET ADDRESS Mt. Airy-Rural	
3. NAME OF DECEASED (Type or print) SAMUEL		First JOSEPH	Middle RODERICK
Last RODERICK		4. DATE OF DEATH March 16, 1960	Month Day Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1899
9. AGE (In years last birthday) 60		10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Fair Grounds	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Augustus E. Roderick	
14. MOTHER'S MAIDEN NAME Clara M. Crouse		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 214-10-3040		17. INFORMANT Mrs. Louise H. Roderick-Same as Item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Bronchogenic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 6 months	
DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3/13 , 19 60 , to 3/16 , 19 60 , that I last saw the deceased alive on 3/16 , 19 60 , and that death occurred at 10:30A , from the causes and on the date stated above.			
ACTUAL SIGNATURE Richard C. Reynolds		ADDRESS (Street, city or town, state) East Church Street	
PHYSICIAN'S NAME (Type) R. C. Reynolds, M.D.		DATE SIGNED 3/18/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 19, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery
22d. LOCATION (City, town, or county) Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 21 '60	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

INSTRUCTIONS

TO PENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03280

CERTIFICATE OF DEATH

3322

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Frederick	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY Frederick
TOWN Rural Mt. Airy	LENGTH OF STAY (in this place)	TOWN Rural Mt. Airy	(If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	15 yrs.	STREET ADDRESS	R.D.# 4
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
VIRGIE L. RUBY		March 14, 1960	
S. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	Married	April 16, 1905
9. AGE last birthday yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
54	Domestic	Maryland	U.S.A.
13. FATHER'S NAME		14. MOTHER'S M AIDEN NAME	
William Ruby		Amanda Horton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
-----		-----	
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Lester P. Fritz, R.D.#4 Maryland		IMMEDIATE CAUSE (A) <u>hemorrhage</u> ANTECEDENT CAUSE(S) DUE TO <u>liver</u> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>liver</u> (C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH <u>udden</u> <u>days</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from , 19....., to , 19....., that I last saw the deceased alive on , 19....., and that death occurred at A.M., from the causes and on the date stated above. SIGNATURE <u>J. H. Egg</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-17-1960	
24. REC'D BY REGISTRAR		NAME OF CEMETERY OR CREMATORIALy	
DATE MAR 17 '60		LOCATION (City, town, or county) (State)	
C. M. WALTZ, Winfield, Maryland		Frederick Co. Maryland	
REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

ST. BONAVENTURE UNIVERSITY TO THE STATE OF NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03281

3287

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Frederick MARYLAND		Maryland Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RFD # 3, Frederick, Md.	
Frederick Memorial		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Reinhold			RUHLEMANN
4. DATE OF DEATH		Month	Day
		March	18
		Year	1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 14, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Meat Cutter		Markets	Germany
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Unknown		Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		578-09-0504	Lene H. Ruhleman
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Frederick, Md. RD	
492X Bilateral pneumonitis		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Arterio sclerotic heart disease			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>Jan. 11</u> , 1960, to <u>March 18</u> , 1960, that I last saw the deceased alive on <u>March 18</u> , 1960, and that death occurred at <u>555 P M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
Ralph L. Michels, M.D.		Shopping Center	
PHYSICIAN'S NAME (Type)		Frederick, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM
Burial		3-21-60	Fort Lincoln Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D. BY REGISTRAR
Raymond E. Creager		Thurmont, Maryland	MAR 22 '60
			24b. REGISTRAR'S SIGNATURE
			Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this form should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3323

CERTIFICATE OF DEATH

Reg. Dist. No.

03282

1. PLACE OF DEATH a. COUNTY FREDERICK		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY FREDERICK				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RURAL		d. STREET ADDRESS RURAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) EMMA MAY SAYLER		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC 13-1873	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA				
13. FATHER'S NAME WILLIAM GEISELMAN		14. MOTHER'S MAIDEN NAME LAURA STITELY								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ISHAAC N SAYLER		Address UNION BRIDGE RURAL				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Myocardial degeneration Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO deabetes (c)										INTERVAL BETWEEN ONSET AND DEATH 7 Wks 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) UNION BRIDGE	(County) MARYLAND	(State) MD		
21. I certify that I attended the deceased from 1-4-1959 to 3-15-1960 that I last saw the deceased alive on 3-15-1960 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.										
ADDRESS (Street, city or town, state) UNION BRIDGE MD 3-15-60										
DATE SIGNED 3-15-60										
ACTUAL SIGNATURE J. H. Hegg		M.D.		UNION BRIDGE MD 3-15-60						
PHYSICIAN'S NAME (Type) J. H. HEGG MD				UNION BRIDGE MD						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/18/60		22c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK		22d. LOCATION (City, town, or county) CARROLL CO. MD		(State) MD		
23. FUNERAL DIRECTOR'S SIGNATURE John Hegg		ADDRESS 103282 Union Bridge Md		24a. REC'D BY REGISTRAR DATE MAR 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Knott				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 To be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

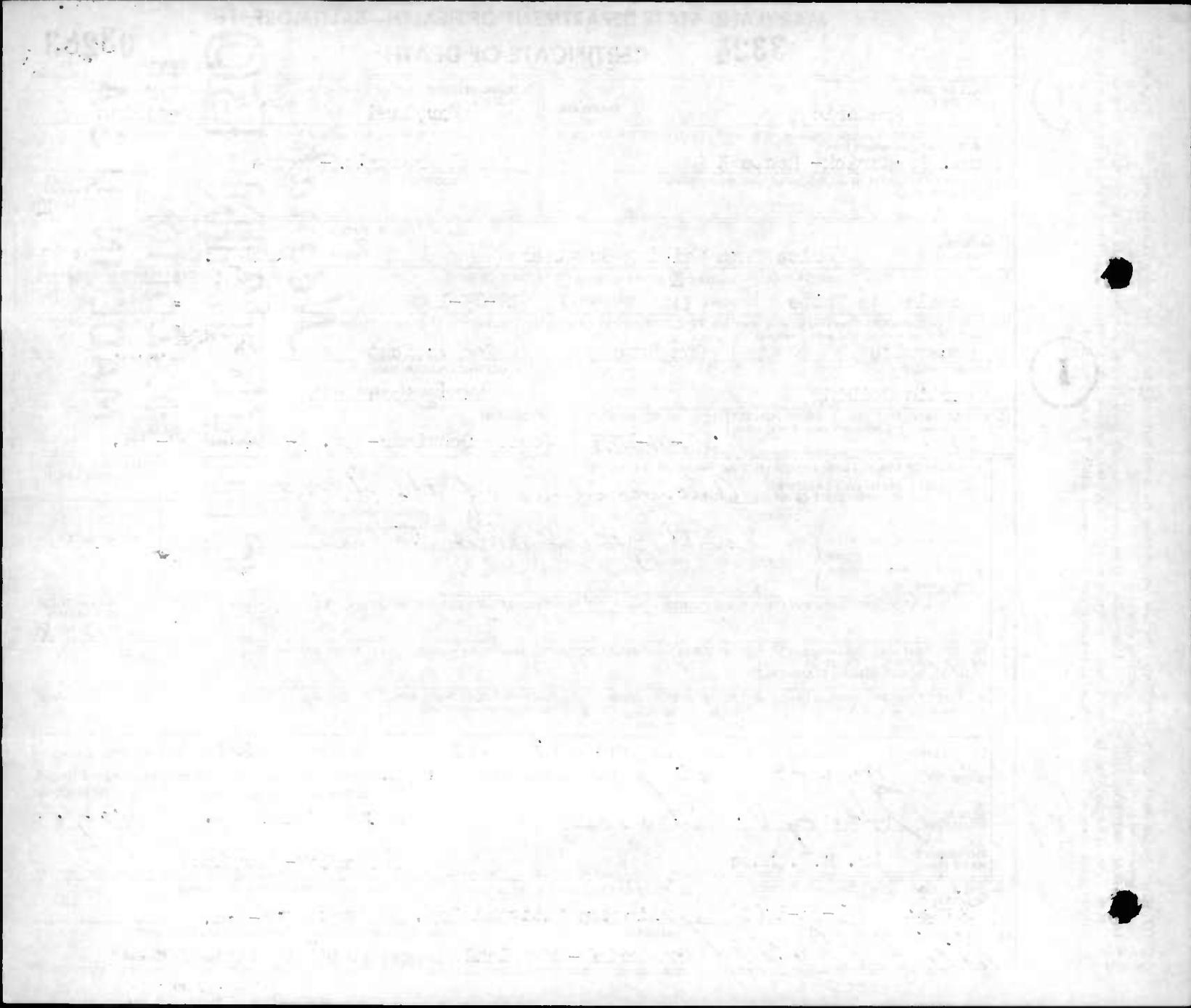
3324

CERTIFICATE OF DEATH

Reg. Dist. No.

03283

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Frederick- Route 3		c. LENGTH OF STAY IN 1b /	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Frederick- Route 3	
3. NAME OF DECEASED (Type or print) Louise Emma Weihing Schwimer		d. STREET ADDRESS /	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. SEX Female	5. COLOR OR RACE White	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH 12-23-1902
8. DATE OF DEATH March 28th	9. AGE (In years last birthday) 57 yrs.	10. IF UNDER 1 YEAR Months Doy	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Connecticut	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Martin Weihing	14. MOTHER'S MAIDEN NAME Emma Eisehardt	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 041-09-1093		INFORMANT Joseph Schwimer- Rt. 3- Frederick- Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of the heart</i> 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <i>with generalized metastases</i> DUE TO DUE TO (c) <i></i> DUE TO			
INTERVAL BETWEEN ONSET AND DEATH 2 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Nov. 19, 1959</i> , to <i>March 28, 1960</i> , that I last saw the deceased alive on <i>March 24, 1960</i> , and that death occurred at <i>4:15 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Henry V. Chase</i> M.D.	ADDRESS (Street, city or town, state) <i>4 East Church St.</i>		DATE SIGNED <i>3/28/60</i>
PHYSICIAN'S NAME (Type) Dr. H. V. Chase	Frederick- Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-31-1960	22c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cem.	22d. LOCATION (City, town, or county) Fort Myer- Va.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert E. Dailey Jr.</i>	ADDRESS Frederick- Maryland	24a. REC'D BY REGISTRAR DATE MAR 30 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03284

CERTIFICATE OF DEATH

Reg. Dist. No.

3283

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN lb Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		d. STREET ADDRESS 232 East Fifth Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 232 East Fifth Street						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) JOHNNIE		First CORNELIA	Middle SHEWBRIDGE	Last	4. DATE OF DEATH March 26, 1960	Month March	Day 26	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 June 1892		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 DAYS 7 Hours 8 Min. 00		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Johnnie Nunberger		14. MOTHER'S MAIDEN NAME Annie Carey						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Mrs. Mary L. Logan, Baltimore 31, Md.		205 S. Register St., Baltimore 31, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 199.2 (b) DUE TO (c) DUE TO				Cancer, etiology or primary site unknown 8 months		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April , 19 60 , to 3-26- , 19 60 , that I last saw the deceased alive on Jan 30 , 19 60 , and that death occurred at 12:45 p. m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 220 N. Market St.						DATE SIGNED 28 March 1960		
ACTUAL SIGNATURE <i>Rex R. Martin</i>		M.D.						
PHYSICIAN'S NAME (Type) Rex R. Martin, M. D.		Frederick, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-29-60		22c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		22d. LOCATION (City, town, or county) Frederick, Maryland (State)		
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		ADDRESS M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

2. ~~newspaper~~ ~~newspaper~~ ~~newspaper~~

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03285

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3289

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Poplar Springs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Mem. Hospital		d. STREET ADDRESS RFD #3, Mt. Airy	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First RALPH	Middle -	Last Shipley
4. DATE OF DEATH	Month 3	Day 15	Year 1960
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1902
9. AGE (In years lost birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic	10b. KIND OF BUSINESS OR INDUSTRY Farm Machinery	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William A. Shipley	14. MOTHER'S MAIDEN NAME Carrie Dempsey		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) W.W.#2	17. INFORMANT Mrs Arlean F. Shipley, Mt. Airy, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident			
INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis with bleeding esophageal varices			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/17 19 60 to 3/15 19 60 , that (I) (we) last saw the deceased alive on 3/15 19 60 and that death occurred at 7:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Richard C. Reynolds		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 3/14/60
22c. PHYSICIAN'S NAME (Type) Richard C. Reynolds		22d. ADDRESS Frederick, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/18/60	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Poplar Springs Meth. Damascus, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Olin L. Wollsworth		25a. REC'D BY REGISTRAR DATE MAR 21 '60	25b. REGISTRAR'S SIGNATURE Isaac S. Trahan

STATE OF MASSACHUSETTS

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RECEIVED
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JULY 10 1968

MAILED
JULY 10 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3290

CERTIFICATE OF DEATH

Reg. Dist. No.

03286

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 3-21-60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY		First GOLDSBORO	Middle STAUFFER
4. DATE OF DEATH March 29, 1960	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 15 Feb 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farm Tenant	10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Walkersville, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Clay Stauffer	14. MOTHER'S MAIDEN NAME Margaret V. Cramer	INFORMANT William C. Stauffer (Same as item #2)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-10-4384	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
Duodenal ulcer, Benign INTERVAL BETWEEN ONSET AND DEATH 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 25 March, 1960 to 29 March, 1960 that I last saw the deceased alive on 28 March, 1960 , and that death occurred at 7:05 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Melvin E. Lea</i>	M.D. Frederick Medical Center 30 March 1960		
PHYSICIAN'S NAME (Type) Melvin E. Lea, M. D.	ADDRESS Frederick, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-1-60	22c. NAME OF CEMETERY OR CREMATORIUM Glade Cemetery	22d. LOCATION (City, town, or county) Walkersville, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE APR 1 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3291

CERTIFICATE OF DEATH

Reg. Dist. No. 103287

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE										
Frederick MARYLAND		Maryland b. COUNTY										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Dickeson										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick Memorial Hosp' Pt. #1										
e. STREET ADDRESS		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First	Middle									
Patricia		Trene	Stine									
4. DATE OF DEATH		Month	Day									
March		1	1960									
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.			
Female		White		February 29, 1960	2	0	0	21	0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME										
Mr. Earl Edward Stine		Himes, Catherine Elizabeth										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address						
(If yes, give war or dates of service)				MOTHER Mrs. Earl. E. Stine								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrocephalus</u> 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <u>Meningocele</u> DUE TO (c)												
INTERVAL BETWEEN ONSET AND DEATH 10 months death												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
21. I certify that I attended the deceased from <u>2/29</u> , 19 <u>60</u> , to <u>3/1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/29</u> , 19 <u>60</u> , and that death occurred at <u>9:30 A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Frederick, Maryland								DATE SIGNED 10/10/60		
ACTUAL SIGNATURE James B. Thomas		M.D.										
PHYSICIAN'S NAME (Type) James B. Thomas												
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/3/1960		22c. NAME OF CEMETERY OR CREMATORIUM Locust Grove		22d. LOCATION (City, town, or county) Unionville rural Fred, CO, MD		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE E. B. Barton		ADDRESS Walkersville Md		24a. REC'D BY REGISTRAR DATE 10/10/60		24b. REGISTRAR'S SIGNATURE John C. Barton						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Part 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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84 DEPARTMENT OF MATHEMATICAL SCIENCES • UNIVERSITY OF ALABAMA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03288

3325

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 To be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md		b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Centerville		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural- Centerville		d. STREET ADDRESS Ijamsville P.O.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ijamsville- P.O.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH Thompson	Month 3	Day 26	Year 1960
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4-1875		9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Frederick-CO Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lloyd Thompson		14. MOTHER'S MAIDEN NAME Daffayne Chase						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-5441		INFORMANT Ijamsville George Thompson Frederick Co. Md				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO Advanced hyper tension (c) DUE TO Marrow aplastic that Disease				INTERVAL BETWEEN ONSET AND DEATH 20-30 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Advanced hyper tension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Washington	
21. I certify that I attended the deceased from olive on		May 22, 1956, to		Mar 26, 1960, that I last saw the deceased and that death occurred at H.P. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Shopping Center		
ACTUAL SIGNATURE Ralph L. Michels				M.D.		DATE SIGNED Frederick, Maryland		
PHYSICIAN'S NAME (Type) Ralph L. Michels								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-29-60		22c. NAME OF CEMETERY OR CREMATORIAL Eberneez		22d. LOCATION (City, town, or county) Frederick, C.O. Md		
23. FUNERAL DIRECTOR'S SIGNATURE L. E. Hicks III		ADDRESS Frederick, Md		24a. REC'D BY REGISTRAR MAR 30 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Thorne		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

332

CERTIFICATE OF DEATH

Reg. Dist. No.

03289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Burkittsville		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Burkittsville	
3. NAME OF DECEASED (Type or print) Walter		First F.	Middle Thrasher
4. DATE OF DEATH 3	Month 6	Day 1960	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/1899
9. AGE (In years last birthday) 61	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner	11. KIND OF BUSINESS OR INDUSTRY farm	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William Thrasher	14. MOTHER'S MAIDEN NAME Ella Miller		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT Mrs. Helen Thrasher, Burkittsville, Md	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Generalized Arteriosclerosis (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3-4 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8/1 , 19 57 , to 3/2 , 19 60 , that I last saw the deceased alive on 3/2 , 19 60 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Middletown Md	
ACTUAL SIGNATURE Kenneth C. Henson	M.D.	DATE SIGNED 3/2/60	
PHYSICIAN'S NAME (Type) Dr. Kenneth Henson	Middletown, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 3/9/1960	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant View Cemetery	22d. LOCATION (City, town, or county) (State) Frederick Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAR 10 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3327

CERTIFICATE OF DEATH

Reg. Dist. No.

03290

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ijamsville		b. COUNTY Loudoun	
c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leesburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Riggs Hospital		d. STREET ADDRESS 83X-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Horatio		First H	Middle Trundle
4. DATE OF DEATH March 12		Month	Day Year 19 60
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Nov 28 1866		9. AGE (In years last birthday) 93 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Leesburg, Va.	
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Horatio Trundle		14. MOTHER'S MAIDEN NAME Elizabeth Travers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INFORMANT Mrs. H. H. Trundle	
17. Address Leesburg, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Generalized Arteriosclerosis DUE TO (c)		20 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 6, 1957</u> to <u>March 12, 1960</u> , that I last saw the deceased alive on <u>March 12, 1960</u> , and that death occurred at <u>7:30 M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ijamsville Md.		DATE SIGNED March 12 1960	
ACTUAL SIGNATURE <i>Joseph Lerner</i> M.D.			
PHYSICIAN'S NAME (Type) Joseph Lerner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 14 Mar. 60	
22c. NAME OF CEMETERY OR CREMATORIAL Union		22d. LOCATION (City, town, or county) Leesburg Va.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph Frederick</i> M.D. House of Feed by J. Hanley Feed		24a. REC'D BY REGISTRAR DATE MAR 16 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03291

CERTIFICATE OF DEATH

Reg. Dist. No.

3328

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural RD#5		c. LENGTH OF STAY IN 1b Since-1949	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridge Road-Braddock Heights		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELINOR		First	Middle
		ELINOR	WARE
4. DATE OF DEATH		Month March	Day 24,
		Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4 March 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Professor		10b. KIND OF BUSINESS OR INDUSTRY Hood College	11. BIRTHPLACE (State or foreign country) Geneva, New York
13. FATHER'S NAME Walter C. Ware		14. MOTHER'S MAIDEN NAME Zaida Quick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-30-9305	INFORMANT Miss Elizabeth L. Towle (Same as item #1)
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs Carcinoma of breast	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1, 1960</u> , to <u>March 24, 1960</u> , that I last saw the deceased alive on <u>March 23, 1960</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>L. R. Schoolman</u>		ADDRESS (Street, city or town, state) M.D. 228 N. Market St., Frederick, Md. DATE SIGNED 25 March 1960	
PHYSICIAN'S NAME (Type) L. R. Schoolman, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
22b. DATE THEREOF 3-25-60		22c. NAME OF CEMETERY OR CREMATORY Taunton, Massachusetts	
22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 28 '60	
		24b. REGISTRAR'S SIGNATURE <u>Caribou L. Etchison</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03292

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 10 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-troussal permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

3329

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick-Rural		c. LENGTH OF STAY IN 1b Minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 Miles North Of Frederick on U.S.#15		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Frederick	
3. NAME OF DECEASED (Type or print) First ROBERT Middle LEE ROY		4. DATE OF DEATH Month March Day 14, Year 1960	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH January 2, 1932	
9. AGE (In years last birthday) 28 yrs.		10. UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Automobiles	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lucille Wheeland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 160-26-3975	
17. INFORMANT Korean Conflict		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CRUSHED SKULL WITH DISTRUCTION OF BRAIN 816X DUE TO Crushed Chest Conditions, if any, which gave rise to immediate cause (b) DUE TO Multiple Fractures PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Auto Ran Beneath Tractor Trailor	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Ran Beneath Tractor Trailor		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 2:15 p.m. 3/14/ 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Harmony Grove, Frederick, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE B. O. Thomas		DATE SIGNED 3/14/1960	
EXAMINER'S NAME (Type) B. O. Thomas, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 3/14/1960	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS M. R. Etchison & Son, Frederick, Maryland		22d. LOCATION (City, town, or county) Hanover (State) Indiana	
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 15 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Krause			

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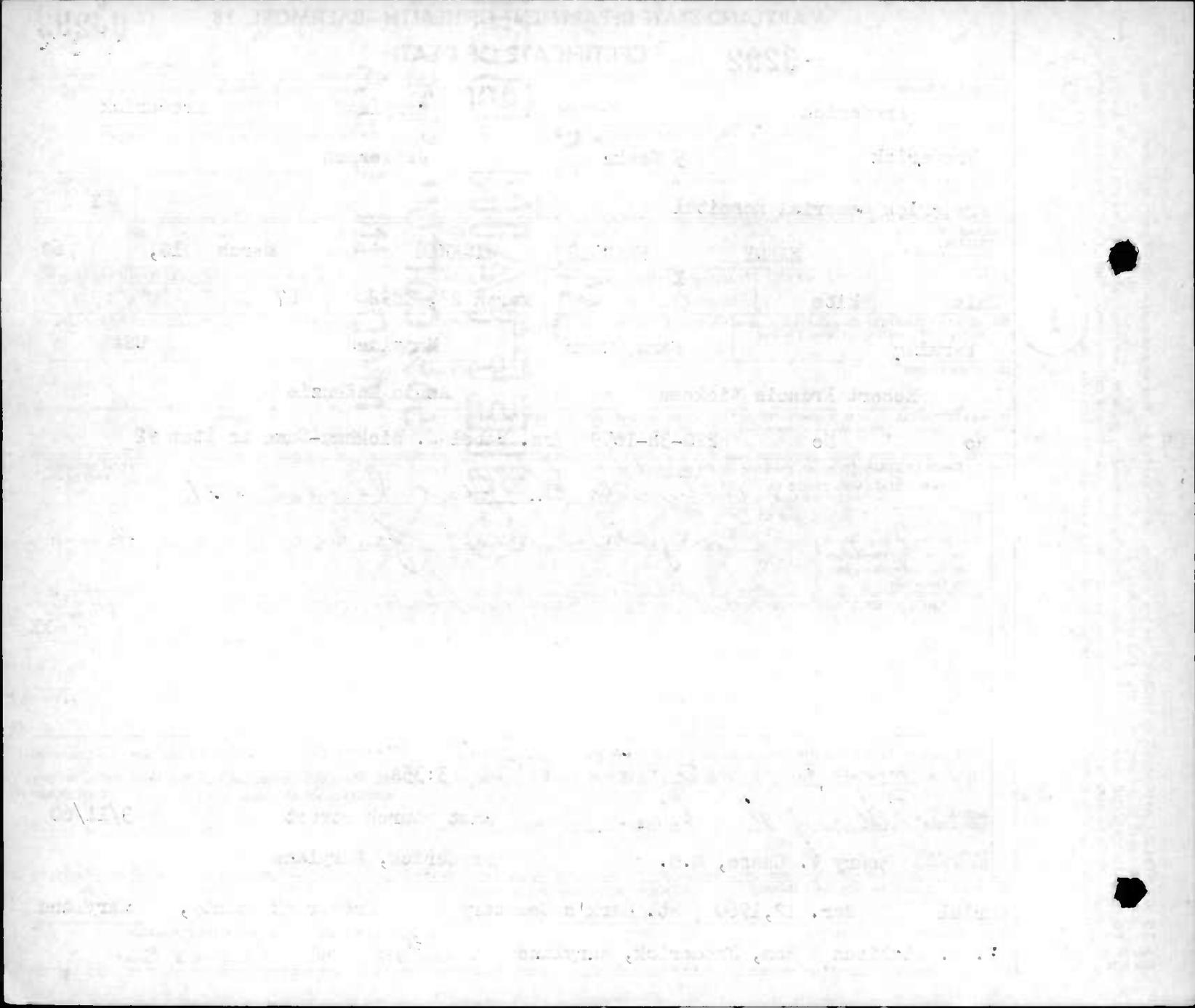
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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b 5 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jefferson	
d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First HARRY	Middle FRANCIS	Last WICKHAM
4. DATE OF DEATH	Month March	Month 10,	Day 19
5. SEX	6. COLOR OR RACE Male	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 23, 1892
9. AGE (In years last birthday) 67	10. IF UNDER 1 YEAR Months 07	11. IF UNDER 24 HRS. Hours 00	
12. IF UNDER 24 HRS. Min. 00	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		
10b. KIND OF BUSINESS OR INDUSTRY Farm Owner			11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Robert Francis Wickham		14. MOTHER'S MAIDEN NAME Annie McKenzie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. No	INFORMANT Mrs. Mabel M. Wickham—Same as Item #2	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease with			
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congestive heart failure			
DUE TO 4 years INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 1958 to March 10, 1960 that I last saw the deceased alive on March 9, 1960 , and that death occurred at 3:35 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Henry V. Chase		ADDRESS (Street, city or town, state) East Church Street	
PHYSICIAN'S NAME (Type) Henry V. Chase, M.D.		DATE SIGNED 3/11/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar. 12, 1960	22c. NAME OF CEMETERY OR CREMATORIUM St. Mark's Cemetery	22d. LOCATION (City, town, or county) (State) Frederick County, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M. R. Etchison & Son, Frederick, Maryland		24a. REC'D BY REGISTRAR DATE MAR 14 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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CERTIFICATE OF DEATH

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Frederick MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 3-18-60	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Frederick Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Mt. Airy 06X-2	
3. NAME OF DECEASED (Type or print) Daniel		d. STREET ADDRESS	
4. DATE OF DEATH March 21 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-1904
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Daniel Williams		14. MOTHER'S MAIDEN NAME Lucy Ryan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT ? Mabel Williams, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO uremia 10 yrs. INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ADDRESS (Street, city or town, state)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/18, 1960, to 3/21, 1960, that I last saw the deceased alive on 3/21, 1960, and that death occurred at 4:55 AM, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Henry V. Chase</u> M.D. ADDRESS (Street, city or town, state) <u>4E-Church St</u> DATE SIGNED <u>3/21/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-24-1960	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion		22d. LOCATION (City, town, or county) Carroll Co., Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C.M. Waltz		24a. REC'D BY REGISTRAR DATE MAR 24 '60	
ADDRESS Winfield, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Khan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this certificate should be detached for use as the burial-transit Permit. Then please remove carbon paper. Please and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Date of Death

Place of Death

Cause of Death

Time of Death

Name of Person

Age of Person

Name of Hospital

Name of Doctor

Name of Physician

Name of Hospital

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Frederick		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick		c. LENGTH OF STAY IN 1b Since 4-16-58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Maryland Odd Fellows Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick, Maryland	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First IVA	Middle VIOLA	Last WOOTTON
4. DATE OF DEATH	Month March	Day 7,	Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 June 1880
9. AGE (In years less birthday) 79	10. IF UNDER 1 YEAR yrs. Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work	10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John O. Perin		14. MOTHER'S MAIDEN NAME Emma F. Burkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Odd Fellows Home Records (Same as item #1)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		INTERVAL BETWEEN ONSET AND DEATH 2 Weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on March 7, 19 60 , and that death occurred at 11:10P	Jan. 19 60, to March 7, 19 60	that I last saw the deceased M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state) 4 E. Church St. DATE SIGNED 8 March 1960
ACTUAL SIGNATURE <i>W. M. Smith</i>	M.D.		
PHYSICIAN'S NAME (Type) William M. Smith, M. D.	Frederick, Md.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/10/60	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard	ADDRESS 4107 Wilkens Avenue	24a. REC'D BY REGISTRAR MAR 10 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Krause

